BodyWise Acupuncture & Total Wellness

885 Canarios Court
Suite #110
Chula Vista, CA 91910
Tel: (619) 656-5102
Fax: (619) 656-5103

955 Lane Avenue
Suite #201
Chula Vista, CA 91914
Tel: (619) 421-9521
Fax: (619) 421-9568

INFORMED CONSENT AND DISCLOSURE

By signing below, I do hereby voluntarily request and consent to be treated with acupuncture and/or substances from the Oriental Materia Medica (Herbal Medicine) by a licensed acupuncturist at BodyWise Acupuncture & Total Wellness, Inc. The scope of acupuncture treatment also involves other procedures including, but not limited to, those outlined and described below.

Acupuncture: Is considered a safe method of treatment. I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor/slight bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. There have been rare instances reported in which a patient developed a scar or infection or sustained a pneumothorax. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Chinese Herbs: I understand that substances from the Oriental Materia Medica (Herbal Medicine) may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call my practitioner as soon as possible.*

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture which uses micro-current electricity to stimulate acupuncture points. A mild tingling sensation of electricity will be felt. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

Tui-Na Massage/Acupressure: This technique involves rubbing, kneading, pressing, rolling, etc. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is uncomfortable.

Moxibustion: This technique requires burning of an herbal material near the skin (indirect), on an acupuncture needle (indirect), or directly on the skin. I understand there is a risk of burning or scarring from its use and that I may refuse this therapy.

Cupping: This technique involves a localized suction produced by heating a small glass cup. I understand there is a possibility of local bruising from the suction and slight burning or blistering due to the heat involved with this technique and that I may refuse this therapy.

Gua Sha: This technique involves scraping over a small area by using a smooth-edged instrument. I understand there is a possibility that local bruising is likely to occur at the site where Gua Sha is performed and that I may refuse this therapy.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment that involves the above procedures for my present condition(s) and any future conditions. I have the right to refuse or discontinue any treatment at any time and understand that this refusal may affect the expected results.

Signature: _____ **Date:** _____

Printed Name: _____ **Date of Birth:** _____