**Elemental Health LLC**

**CONSENT TO TREAT**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize Caroline Craig Proctor of Elemental Health LLC to perform acupuncture treatments on me.

Scope of Practice

I understand that the scope of practice includes, but is not limited to, the following:

• Using Oriental medical theory to assess, diagnose and develop a treatment plan in an attempt to improve overall body function and/or to relieve pain

• Using treatment techniques that may include:

* Insertion of sterile acupuncture needles through the skin
* Acupuncture stimulation including, but not limited to, electrical stimulation or the application of heat with moxibustion
* Cupping
* Dermal friction
* Acupressure
* Herbal therapies
* Dietary counseling based on traditional Chinese medical principles
* Breathing techniques or exercise according to Oriental medical principles

Risks and Possible Side Effects

I understand that there are possible side effects to my treatment that may include the following:

• Minor pain or soreness in the treatment area, transient bruising, dizziness, nausea, fainting, sensations of heat, cold, tingling or numbness, skin irritation or slight bleeding at needle site, generalized fatigue, gastrointestinal disturbance from herbal prescriptions, minor burns from moxibustion, pneumothorax, infection.

I understand the full communication regarding my experience during and following the treatment is my responsibility and that every effort will be made on the part of Elemental Health, LLC to avoid these possible side effects.

Treatment Outcomes

I understand that no promises or guarantees can be made regarding the outcome of treatment and that reasonable efforts will be made to give me information so that I might make educated decisions regarding the duration and appropriateness of continued care. I understand that I may stop treatment at any time. For Student

Western Biomedical Diagnosis

I understand that it is not within the scope of practice for acupuncturists to offer Western medical (biomedical) diagnosis and that it is my responsibility to seek such diagnosis elsewhere if I have not already done so.

**I have / have not (circle one)** been examined by a licensed physician or other licensed health care provider with regard to my illness or injury. If yes, I have informed the practitioner of the diagnosis.

I **do / do not (circle one)** have a pacemaker or bleeding disorder.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_