Consent to Treatment

I, _____, hereby authorize Erin Gagnon, Lic. Ac. to administer any style of Oriental Medicine relevant to my diagnosis and treatment, including but not limited to the following.
   (Please check any boxes you DO NOT GIVE your consent for)

☐ Insertion of various styles and sizes of acupuncture needles into my body at various depths and locations.

☐ Heat treatments using Artemesia vulgaris (moxibustion, "moxa") or a conventional heat lamp. Indirect moxibustion treatments involve putting moxa on the head of the needle or on top of a barrier such as salt or a slice of ginger. With any type of heat, there is always a risk of a burn.

☐ A massage technique called "gwa sha". This treatment leaves redness on the skin that can last for 1-5 days. Slight bruising and tenderness may persist after the treatment.

☐ Cupping may be used to promote circulation of Qi (energy) through the meridians. Cups may produce a red/purple color on the area treated lasting for 1-5 days.

☐ Electrical stimulation of the needles may be used which produces a vibration or tapping sensation.

☐ Bloodletting, alone or in conjunction with cupping, may be used to improve circulation in specific meridians. Lancets are inserted into the skin and a small amount of blood is expressed from the puncture.

☐ Chinese Herbal Medicine, in various forms such as pills, capsules, extract powders, and raw herbs, to be administered orally and /or topically. Some patients may experience side effects from their particular prescription. Please inform me of any adverse effects you may be experiencing.

I have been informed that I have the right to refuse any form of treatment. I understand the nature of the treatment, have been informed of the risks and possible consequences involved with this treatment, and have been given an opportunity to ask questions pertaining to the treatment. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment.

Signature of patient: _____

Printed name of patient: _____

Date: _____