CONSENT TO TREATMENT

I, _____, hereby authorize the Licensed Acupuncturists working at 360 NeuroMuscular Therapy, LLC to administer treatment of acupuncture, adjunctive techniques and herbal medicine relevant to my diagnosis.

The patient has the right to refuse any form of treatment. I understand that acupuncturists practicing in the state of Massachusetts are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended.

Treatment may include but is not limited to the following:

1. Insertion of various styles and sizes of acupuncture needles into my body at various depths and locations.
2. Heat treatments using conventional heat lamp or moxibustion (Artemesia Vulgaris). With any heat treatment exists the risk of burn.
3. Massage technique or gua sha. This technique may cause redness on the skin at the sight of treatment that may last approximately 1 – 7 days. Slight bruising and tenderness may persist after the treatment.
4. The placement of suction cups on the skin. These cups may produce a red or purple mark on the skin at the sight of the cup that may last approximately 1 – 7days. Slight bruising and tenderness may persist after the treatment.
5. Electrical stimulation of the needles may be used producing a tapping sensation at the needle location.
6. Herbal medicine, administered in various forms including tablets, capsules, extracts powders, raw herbs, and liniments. These herbs are taken orally and/or topically. Some patients may experience side effects including but not limited to upset stomach or nausea.

I have been informed that I have the right to refuse any form of treatment. I understand the nature of the treatment and have been given the opportunity to ask questions pertaining to the treatment. I also understand there is always a possibility of an unexpected complication and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantee can be made concerning the results of treatment.

Signature of Patient or Legal Guardian: _____

Printed name of Patient: _____

Date: _____