

Wisdom Ways Acupuncture

373 W. Drake Road Suite 5A Fort Collins, Colorado 80526 Phone (970) 227-3077

Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or Chinese Medicinal substances by Inger Giffin, L.Ac. I understand that acupuncturists practicing in the state of Colorado are primary care providers and that regular primary care by a licensed physician may also be an important choice, and is recommended by Inger Giffin L.Ac.

Acupuncture/Moxibustion: 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 bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. 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.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica 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 Wisdom Ways Acupuncture as soon as possible.*

Cupping/GuaSha: I understand that I may also be given Cupping or Gua Sha as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. 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 too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. 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.

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.

Signature: _____

Date: _____

Printed Name: _____

Date of Birth: _____

Address/City/Zip: _____ OK to send mail here? _____

Email address: _____ OK to send email here? _____

Home Phone: _____ Can we leave msgs here? _____ Cell: _____ Can we leave msgs here? _____

SIGN BELOW TO AGREE TO CANCELTION POLICY:

I have read and agree to the cancellation policy which states that my first no-show or appointment that is canceled within 24 hours (late cancel) of my appointment will be charged at 50% of the regular full treatment fee, while all future no-shows or late cancels will be charged the full treatment fee. I agree to have this fee automatically charged to my credit card if I have it on file with Inger Giffin, or to be deducted from my package if I have pre-paid. Otherwise I will pay this fee before my next treatment.

X _____

Patient's Signature

Date