**Consent to Receive Treatment Form**

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medical by a licensed acupuncturist representing TCM Whole Health, Inc. DBA Acupuncture Associates of Castle Rock. I understand that acupuncturists practicing in the state of Colorado are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic’s practitioners.

**Acupuncture:** I understand that acupuncture is performed by the insertion of needles through the skin 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.

**Chinese Herbs:** I understand that substances from the Oriental Materia Medical 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 TCM Whole Health, Inc. as soon as possible.*

**Acupressure/Cupping/Gua Sha/Tui-Na Massage:** I understand that I may also be given adjunctive treatments 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: mild electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

**Heart Sound Nutrition Assessment Patient Consent Form:** I give **­Acupuncture Associates of Castle Rock** permission to record the sound of my heart and to create a graph of that sound on the Heart Sound Recorder (a general wellness cardiac stress monitor). I have been informed and understand that the Heart Sound Recorder is not an electrocardiograph like those in hospitals or physicians and that it is not capable of   
diagnosing heart conditions and is not in any way a substitute for such a device. I further understand that the Heart Sound Recorder has not been reviewed or cleared by the US Food and Drug Administration. I understand that if I have or believe I have a heart condition, that I should see a physician qualified to evaluate and treat that condition. Any suggested nutritional or dietary advice is not intended as treatment or therapy for any disease or symptom of disease. Nutritional counseling, supplement recommendations, and exercise considerations provided to me are to support the normal physiological processes of the body. I understand that any techniques, treatments, or lifestyle changes suggested after the use of this device should be undertaken only with the guidance of a licensed physician, therapist, or healthcare practitioner. The findings from this device can be used to support but should not be used in place of sound medical therapies and recommendations. I am giving permission to **­Acupuncture Associates of Castle Rock** to share my graph with other practitioners for educational purposes only so long as my name and other personal information are removed.

**Tibetan Herbal Foot Soak:** I understand that I hereby request and consent to perform a Tibetan Herbal Foot Soak in office as a standalone treatment or added on to an acupuncture treatment or being purchased for use at home. I have been informant that the Tibetan Herbal Foot Soak is a generally safe method of treatment, but it may have some side effects or temporary reactions such as: Redness of the skin being soaked, Itching, Increase in pain, Increased heart rate, Slight sweating. There is no implied or stated guarantee of success or effectiveness of this specific treatment or series of treatments. While I do not expect the Acupuncture Associates of Castle Rock to be able to anticipate and explain all possible risk and complications of this treatment, I wish to rely on Acupuncture Associates of Castle Rock to exercise judgment during treatment either at home or in the office which Acupuncture Associates of Castle Rock thinks, at the time, based upon the facts then known, is in my best interest. I will inform my practitioner immediately if I have any of the following conditions and will discontinue use until I speak to my practitioner: Open wounds on feet or ankles, Have or Had metastatic cancer, are breastfeeding or pregnant, are taking blood thinners.

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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_