CASCADIA
HEALTH CARE, P.C.

4916 NE St. Johns Road, Vancouver, WA 98661
(360) 694-4811

Acupuncture Consent Form

Date_____

Patient Name_____

I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materal Medica administered by a licensed acupuncturist at Cascadia Health Care, P.C. I understand that acupuncture is performed by the insertion of needles through the skin, or by the application of heat to the skin, or by both, at certain points on or near the surface of the body in an attempt to treat bodily dysfunctions or diseases, to modify or prevent the perception of pain, and to make normal the body's physiological functions.

I understand that certain side effects may result. These may include, but are not limited to, some local bruising, minor bleeding, light headaches, temporary pain or discomfort, and the possible temporary aggravation of symptoms existing prior to acupuncture treatment.

I am also aware that, although acupuncture is licensed in Washington and many other states, and has been safely practiced for centuries, the Federal Government classifies the procedure as "experimental." 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.

I understand that acupuncturists may recommend substances from the Oriental Materia Medica to treat bodily dysfunctions or diseases to modify or prevent the perception of pain. I understand that I am not required to take these substances, but must follow the directions for administration and dosage if I decide to take them. I understand that certain adverse side effects may result from taking these substances. These could include, but are not limited to, changes in bowel movement, temporary abdominal pain or discomfort, and the possible temporary 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 the acupuncturists at Cascadia Health Care, P.C.

I also understand that appointment times are reserved. 24 hours notice of any change is appreciated. Full fee will be charged for missed appointments. Unless other arrangements have been made, I understand that payment is due at the end of each visit.

I have carefully read and I understand all the foregoing and so am fully aware of what I am signing.

X_____ Date _____

PATIENT SIGNATURE

X_____ Date _____

SIGNATURE OF PARENT OR GUARDIAN (IF PATIENT IS A MINOR)