INFORMED CONSENT TO TREATMENT

Treating children while nourishing the family

Little Owl Medicine • 513 NE Schuyler Street, Portland, OR 97212 • 503 312-4223 • www.littleowlmedicine.com

INFORMED CONSENT TO TREATMENT

I consent to acupuncture treatments and other procedures associated with Traditional Chinese Medicine. I have discussed the nature and purpose of my treatment with the below named practitioner.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese Massage), Chinese herbal medicine, shonishin massage and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include bruising, nerve damage, and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although this clinic uses sterile disposable single-use needles, and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue.

I understand that the herbs need to be taken according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify my acupuncturist of any unanticipated or unpleasant effects associated with the consumption of herbal medicine.

I will notify my acupuncturist if I am or become pregnant.

I do not expect my acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the below named practitioner to exercise judgment during the course of treatment which he/she thinks at the time, based upon facts then known, is in my best interest.

I understand the clinical medical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent. I authorize my acupuncturist to obtain copies of medical records from other practitioners that I have had a patient/practitioner relationship with my signed consent.

By voluntarily signing below, I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PRINT NAME OF PATIENT

X____

SIGNATURE OF PATIENT (Or Representative)

X____

SIGNATURE OF PRACTITIONER

X__________________________________