ACUPUNCTURE CENTER OF PORTLAND
511 SW 10th AVE, SUITE 1006 · PORTLAND, OR 97205

INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture, herbal therapy, massage treatment and any other procedures within the scope of practice of my provider on me (or on the person named below, for whom I am legally responsible) by any practitioner who now or in the future treats me while employed by or serving as back-up to my regular practitioner at the Acupuncture Center of Portland ("ACP"). I understand that acupuncturists practicing in the state of Oregon are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, ultrasound, Tui-na (oriental manual therapy), massage, herbal medicine, exercise and nutritional counseling. I understand and agree that any herbs prescribed to me need to be consumed according to the instructions provided orally and/or in writing. The herbs may have an unusual smell, taste, or texture.

I have been informed that acupuncture is a generally safe method of treatment, but that some side effects may occur, including soreness, tightness, redness, bruising, numbness or tingling near the needling sites that may last a few days or more, occasional dizziness or rarely fainting. Risks of acupuncture could conceivably include nerve damage or organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, and burns and/or scarring are a potential risk of moxibustion. Bruising is a common side effect of cupping. Electrical stimulation of the muscles or acupuncture needles may be used and may result in a tingling, pulsing or jumping sensation when applied. I understand that some herbs may interact with prescription drugs, over the counter medication, and supplements, and as such, I will notify my practitioner if I am taking any medications concurrently with Chinese herbs. Patients with sever bleeding disorders, pacemakers, diabetes, contagious diseases, or lymphedema should inform practitioner prior to beginning treatment. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

I have been informed that massage therapy is a generally safe method of treatment, but that it may have some side effects, including bruising, soreness, and the possible aggravation of symptoms after treatment. I understand that some herbs may be inappropriate during pregnancy. Unwanted effects from the herbs may occur, the most common being digestive upset. If I suspect I am having an unwanted effect, I will discontinue the herbs and will immediately notify ACP of the unwanted effects that I feel may be associated with the consumption of the herbs. Some possible side effects of taking herbs could be nausea, gas, stomachache, headache, diarrhea, and rarely, hives, vomiting, or tingling of the tongue. **I will notify my ACP practitioner if I am or become pregnant during the course of treatment.**

I do not expect my practitioner or ACP to anticipate and explain all possible risks and complications of treatment. I understand that risks are involved and that results are not guaranteed.

In no event shall ACP, its employees, or agents be liable for direct, special, incidental, or consequential damages in connection with any services or goods supplied by ACP. In no event shall any liability exceed an amount equal to the cost for the services or goods actually paid by the patient that give rise to the liability. Except as expressly provided herein, ACP disclaims all other liability in connection with the services rendered and/or goods provided, whether such claim or liability be based upon contract, tort, or other legal theory, including negligence and strict liability in tort. I acknowledge that my sole right of recovery against my practitioner and ACP, directly or indirectly, is limited to the amounts I actually pay for services and/or the cost of the goods supplied.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of treatment, and have had the 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.

Patient (or Guardian) Signature:_____**Date**_____

Patient (or Guardian) Printed Name:_____