



INFORMED CONSENT TO RECEIVE TREATMENT

By signing below, I _____ do hereby voluntarily consent to be treated with acupuncture, adjunct techniques and herbal medicine by the licensed acupuncturists at Breathe & Balance Acupuncture and Integrative Medicine. I understand that acupuncturists in the state of North Carolina are not deemed as primary physicians and that regular primary care by a licensed MD or NP is an important choice that is strongly recommended by this clinic's practitioner.

I understand that I may refuse any of the following treatments at any time:

Acupuncture: I understand that acupuncture is performed by the insertion of fine sterile needles through the skin at certain points on the body to treat bodily dysfunction or disease, 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 may include, but are not limited to local bruising, minor bleeding, fainting, pain or discomfort, the possible aggravation of symptoms and, very rarely, organ puncture, nerve damage or infection. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop the acupuncture treatment at any time. I therefore give my permission and consent to treatment.

TDP heat therapy: I understand that I may receive TDP ("Teding Diancibo Pu") which is a mineral plate infrared heat lamp that helps reduce pain and inflammation, rebuild cells to accelerate healing. I am aware that certain adverse side effects can occur such as minor burns and possible discomfort from prolonged overheating.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture, a procedure in which pulses of weak electrical current are sent through acupuncture needles into acupuncture points in the skin, 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 am aware that if I have a pacemaker or underlying heart condition that I have made my practitioner aware of this. I understand that I may refuse this treatment all together at any time.

Gua Sha/Cupping: I understand that I may receive gua sha or cupping as part of my treatment. Gua Sha involves repeated pressured strokes over oiled skin with a smooth edge tool like a ceramic Chinese soup spoon. Cupping applies localized suction to the skin with fire and glass cups, drawing the superficial skin and fascia into the cup. Both are used to treat pain, relieve tension, and allow for free distribution of blood and lymph that has otherwise been obstructed. I am aware that certain adverse side effects may result from this treatment. These may include but are not limited to: temporary "road rash" redness, discoloration or bruising, discomfort, on rare occasions blistering and the possible aggravation of symptoms existing prior to treatment.

Tui Na Massage: I understand that I may receive acupressure or tui na massage. I am aware that certain adverse side effects may result, including but are not limited to: bruising, sore muscles or aches and the possible aggravation of symptoms existing prior to treatment.

Herbal or Functional Medicine: I understand that Chinese herbs or nutritional supplementation may be recommended as part of my treatment. I also might be asked to provide recent bloodwork and labs from previous practitioners. I may also be asked to have bloodwork done by my primary care physician or from a third party. I understand that I am not required to take the herbal or nutritional substances but must follow the directions and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These may include but are not limited to: abdominal pain, changes in bowel movement, nausea or vomiting, and the possible aggravation of symptoms existing prior to herbal treatment. If you experience any reported side effects or have concerns with the use of the herbal and nutritional substances, I should stop use immediately and call my acupuncturist.

Nutrition & Lifestyle Advice: In conjunction with my treatment, I may be given dietary and lifestyle advice. Nutritional therapy is an extremely effective means of self-healing, disease prevention and overall wellbeing. Food is medicine. Changing eating habits is difficult and I may experience resistance, irritability, change in bowel movements, change in energy level and possible aggravation of symptoms. I will communicate with my practitioner about any difficulties I may have with specific dietary and lifestyle advice. Patients may also be given exercise or activity advice. Movement is life, while being sedentary ages you faster. I might experience challenges regarding activity frequency and intensity however, completion of the activity suggested is never required. All concerns regarding lifestyle activity should be communicated with the acupuncturist.

Patients who are pregnant, have a pacemaker or heart condition, have a seizure disorder, or those with a bleeding disorder, blood clots, or taking blood thinners should discuss this with the acupuncturists before proceeding with **ANY and ALL** of the above treatment modalities. I understand that there are no guarantees concerning treatment. I understand that I am free to refuse or stop treatment at any time. I have carefully read and understand all the above information. I understand that I may ask my acupuncturist for a more detailed explanation. I give my permission and consent to treatment.

By signing below I agree to the treatments and understand its benefits and possible side effects and waive any rights to hold the treating licensed acupuncturist and Breathe and Balance, LLC, accountable for such.

SIGNED: _____ Date: ____/____/____