INFORMED CONSENT TO TREAT

Angela Soto, O.MD, LAc – Practitioner
Christina McCormack, Jordan Kinard & Nicole Elmiger – Assistants
Blue Root Acupuncture, LLC *Confidential*

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Please read carefully, then indicate your agreement at the bottom by signing and dating.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated above and/or other licensed acupuncturist who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named above, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not. I also hereby request and consent to the performance of Gua Sha and Stretching Exercises to the medical/office assistants of Blue Root Acupuncture.

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, nutritional counseling, botanical medicine, cosmetic acupuncture, cosmetic homeopathic injections, homeopathy, Gua Sha, Ion Cleanse, acupuncture injection therapy, ozone therapy, and prolozone therapy. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs, or any nutritional/botanical supplement. I have been informed that acupuncture and acupuncture injection therapy are generally safe methods of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or blisters and/or scarring are potential risk of moxibustion, cupping, and Gua Sha, or when treatment involves the use of heat lamps. Discoloration is a common side effect of cupping, Gua Sha, and injection therapy. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment, at all times.

I understand that while this document describes the mayor 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 will notify a clinical staff member who is caring for me if I am or become pregnant. While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed. I understand the clinical and administrative staff may review my patient records and lab records, but all my records will be kept confidential and will not be released without my written consent.

By voluntary signing below, I show that I have read or had have read to me, the above 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 indicate that I am seeking and requesting treatment of my own free will and agree not to hold Blue Root Acupuncture, Angela Soto, O.MD, Lac, her employees/contractors, successors or assigns, liable for any injury or loss received as a result of treatment. 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 Signature ______________________ Date ____________

Office Signature ______________________ Date ____________