INFORMED CONSENT TO TREATMENT

By signing below, I do herby voluntarily consent to be treated with acupuncture and all forms of Chinese Medicine by Healthy Roots Massage Therapy & Wellness Centre. I understand that methods of treatment may include, but not limited to, acupuncture, moxibustion, cupping, electrical stimulation, massage, herbal medicine and teas.

Acupuncture is generally a safe treatment form, but may have some minor side effects. These side effects could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, numbness or tingling near the needle site and the possible aggravation of symptoms existing prior to acupuncture treatment. Bruising is a common side effect of cupping. Unusual risks of acupuncture include, nerve damage and organ puncture, including lung puncture. Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns, and or scarring are a potential risk to moxibustion and cupping.

I understand that some acupuncture or massage procedures may be inappropriate during pregnancy. I understand that some herbs may be inappropriate during pregnancy and breastfeeding. **I will notify Healthy Roots Massage Therapy & Wellness Centre if I am or become pregnant or am or will begin breastfeeding.**

I understand that while this document describes major risks of treatment, other side effects and risk may occur. I do not expect Healthy Roots Massage Therapy & Wellness Centre to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on my practitioner to exercise judgment during the course of the treatment which he thinks at the time, based upon the facts then known, is in my best interest.

I understand Healthy Roots Massage Therapy & Wellness Centre may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that there are no refunds for treatments or herbal products.

By voluntarily signing below, I show that I have read or have had read to me, the above consent to treatment. I 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.

_____ _____

Patient Name (please print) Patient Signature / Guardian Signature

_____ _____

Witness Date Signed