

Laurel Wellness

CONSENT TO TREATMENT

Please sign, date and return this form for inclusion in your file. Thank you.



I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, herby authorize Laura Corrigan of Laurel Wellness to administer any style of Oriental Medicine relevant to my diagnosis and treatment, including but not limited to the following:

1. Insertion of various styles and sizes of acupuncture needles into my body at various depths and locations.
2. Heat treatments using Artemesia Vulgaris (moxibustion, “moxa”) or a conventional heat lamp. Indirect moxibustion treatments involve placing moxa on the head of a needle or on top of a barrier such as salt or a slice of ginger. When direct moxa is used, the moxa is place directly on the skin. The heat generated from the moxa may involve slight discomfort or leave a blister or scar on the skin.
3. A massage technique called “gua sha” can leave redness on the skin which may last for 1-5 days. Slight bruising and tenderness may persist after the treatment.
4. Cupping likewise may produce red/purple discoloration to the treated area lasting for 1-5 days.
5. Electrical stimulation of the needles may be used to produce a vibration or tapping sensation or
ion-pumping cords may be attached to the needles.
6. Bloodletting, alone or in conjunction with cupping, may be used to improve circulation by the
application of a lancet to prick points from which a small amount of blood is expressed.

I have been informed that I have the right to refuse any form of treatment. I understand the nature of the treatment , have been informed of the risk and possible consequences involved with this treatment, and have been given the opportunity to ask questions pertaining to the treatment. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made regarding the results of treatment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name of Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Patient or Authorized Guardian

\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_ Date of Birth

\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_ Today’s Date