"The natural choice"

A C U P U N C T U R E • M A S S A G E T H E R A P Y

318 E. Jefferson St. • Butler, PA 16001

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CONSENT TO TREATMENT

I hereby voluntarily consent to be treated by Elizabeth Gibson, R.Ac. with Oriental medical procedures, which may include acupuncture, moxibustion, cupping, gua sha, acupressure, massage, Chinese herbal medicine, or nutrition and lifestyle counseling. Elizabeth Gibson is a licensed Acupuncturist in the state of Pennsylvania.

I understand that acupuncture is performed by the insertion of sterile needles through the skin, or by the application of heat to the skin, or by both, at certain points on or near the surface of the body in an attempt to treat body dysfunctions or diseases and to normalize the body's physiological functions.

I understand that all of my patient records as well as information I share with my acupuncturist will be kept confidential. No records or information will be released without my written consent.

While acupuncture is generally a safe method of treatment, I am aware that certain side effects may result. These could include, but are not limited to, some local bruising, bleeding, dizziness, fainting, temporary pain and discomfort, numbness or tingling near the needling sites that may last a few days and temporary aggravation of symptoms in existence prior to treatment.

I am aware that if there is a worsening of my ailment or condition or if it does not improve within the time estimated by the acupuncturist, or if a new ailment or condition appears that I should consult my personal physician or any other licensed physician.

I understand that I should inform my acupuncturist prior to being treated if I believe I might be pregnant.

I understand that no guarantees concerning acupuncture's use and effects are given to me, and that I am free to stop acupuncture treatment at any time.

None of the foregoing provisions preclude the administration to me of conventional medical therapy by a licensed physician when such therapy is deemed appropriate.

I understand I will be charged the full fee for appointments cancelled with less than 24 hours notice.

I have carefully read and understand all the foregoing and so am fully aware of what I am signing. I have felt free to ask any questions.

Patient_____Date_____