



Informed Consent to Treat

I hereby consent to 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 acupuncturist Zoe Moon Culbertson, Lic. Ac.

Methods of treatment may include but are not limited to acupuncture, shiatsu, moxibustion, cupping, gua sha, electroacupuncture, Chinese herbal medicine or nutritional counseling based on the concepts of traditional Chinese medicine. I have a right to refuse any form of treatment during the session.

I understand that acupuncture is a generally safe method of treatment, but that it may occasionally have some side effects, including bruising, numbness, tingling or pain near the needling site that may last a few days, and in rare cases, dizziness or fainting. Bruising is a common side effect of cupping and gua sha.

I understand that while this document describes the major 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 have informed the acupuncturist of all my known medical conditions and medications, including pregnancy and I will notify Zoe Moon Culbertson, Lic. Ac. of any changes.

Acupuncture treatment is not a substitute for diagnostic medical procedures, medical treatment or medications, and it is recommended that I concurrently work with my Primary Care Physician for any condition I may have. I understand that Zoe Moon Culbertson, Lic. Ac. does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of acupuncture or shiatsu therapy.

I have been informed of the risks and benefits of acupuncture and other procedures and will be given an opportunity during the first treatment session to ask questions pertaining to these procedures. I understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment.

Signature _____ *Date* _____

Name (Printed) _____ *DOB* _____