Consent to Acupuncture Treatment

Vitality Acupuncture, LLC

I, _____, hereby request and consent to the performance of acupuncture, and other procedures within the scope of practice of Oriental Medicine, by Kylah Pata, L.Ac, MSTCM, Dipl. OM. She may 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 sterile, single-use acupuncture needles into my body at various depths and locations.
2. Heat treatment using the herb Arthemesa vulgaris (moxibustion, “moxa”) or a conventional heat or TDP lamp may be placed on or near any part of my body. For indirect moxibustion treatments, the moxa is placed on the head of the needle or barrier (such as a slice of ginger or salt) which rests on the skin. Moxa produces heat and may result in discomfort, or on rare occasions, small burns.
3. A massage technique called guasha (“gwa sha”) may produce redness on the skin which may remain for 1-5 days. A slight bruising or tenderness may rarely persist following the treatment.
4. Cupping may be used to promote the circulation of Qi (energy) through the meridians or to relieve muscle tension and pain. Cups may produce a red/purple color on the area cupped which may remain for 1-5 days.
5. Electrical stimulation may be used to relieve pain, move qi and expedite healing. Estim produces a slight vibrating/tapping sensation on the needles.

I have been informed that I have a right to refuse any form of treatment. I understand the nature of the treatment, have been informed of the risks and possible consequences involved with this treatment, and was given an opportunity to ask questions pertaining to my treatment. I also understand there is always a possibility of unexpected complications and I understand that no guarantee can be made concerning the results of the treatment. I intend this consent form to cover the entire course of my treatment for my present condition and for any future conditions for which I seek treatment.

Signature of Patient: _____

Printed Name: _____

Date: _____

Practitioner Signature: _____