CHI HARMONY ACUPUNCTURE
Copley Square ♦ 581 Boylston St, Suite 603 ♦ Boston, MA 02116
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Consent to Treatment

I, _____, hereby authorize Stephanie A. Smith, Lic. Ac., to administer any style of Oriental Medicine relevant to my diagnosis and treatment, including but not limited to the following. (Please check any boxes you DO NOT GIVE your consent for):

- ☐ Insertion of various styles and sizes of disposable, sterilized acupuncture needles into my body at various depths and locations. I agree to remain lying down during treatment and not to remove or manipulate the acupuncture pins.
- ☐ Heat treatments using Artemesia vulgaris (moxibustion) or a conventional heat lamp. The heat generated from the moxa treatments may involve slight discomfort or leave a blister or scar on the skin. With any type of heat, there is always a risk of a burn.
- ☐ Cupping or a massage technique called "gwa sha" may be used to promote circulation of Qi (energy). They may produce a red/purple color, bruising or tenderness on the area treated lasting for 1-5 days.
- ☐ Electrical stimulation of the needles may be used which produces a vibration or tapping sensation, or ion pumping cords may be attached to the needles.
- ☐ Bloodletting, alone or in conjunction with cupping, may be used to improve circulation in specific meridians. Lancets are inserted into the skin and a small amount of blood is expressed from the puncture.
- ☐ Chinese Herbal Medicine comes in various forms such as pills, capsules, extract powders, and raw herbs, to be administered orally and /or topically according to the oral and/or written directions for administration and dosage. Please inform your practitioner of any adverse side effects you may be experiencing.
- ☐ Qi Gong exercises, which may include but are not limited to light stretching, breathing and meditative exercises, may be taught to modify or prevent pain perception and normalize the body's physiological functions.

I am aware that certain adverse side effects may result from the above treatments, which could include but are not limited to: bruising, sore muscles or aches, allergic reactions, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable. I agree that I will inform the practitioner before beginning treatment if I use a pacemaker, have heart problems, an infectious disease, any known allergies, or metal plates or rods in my body, or if I am or could be pregnant or taking herbs or pharmaceuticals.

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 risks and possible consequences involved with this treatment, and have been given an 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 concerning the results of treatment.

Cancellation Policy: please give at least 24 hours notice if you need to reschedule to avoid a $25 late cancellation fee.

Signature of patient:_____

Printed name of patient: _____Date: _____

Practitioner Signature: _____