CONSENT TO TREATMENT FORM
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By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by licensed acupuncturist, Darcy Forrest, LAc.. I understand that acupuncturists practicing in the state of MAINE are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, nerve damage, pneumothorax, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call your acupuncturist as soon as possible.*

Acupressure/Tui-Na Massage/Fire Cupping/Guasha: I understand that I may also be given acupressure/tui-na massage, fire cupping therapy, or guasha, as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, blisters, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I**NSURANCE:** I understand that I am financially responsible to pay for treatment charges not covered by insurance. I understand that my insurance company may not cover all costs associated with each treatment, and I am responsible for paying those costs not covered. I understand that I am responsible for finding out what my deductible, insurance benefits for acupuncture, and limits are with my insurance company. I understand that co-payments are due at the time of service.

Payment: I understand that payment is due in full at time of service. I understand that appointment no-shows, or cancelled appointments in less than 24 hours of the scheduled appointment, are subject to charges equal to an in-office appointment, and must be paid before the next scheduled appointment in full.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ Date: _____

PrintedName:_____

Acupuncturist signature:_____