# City Acupuncture and Wellness Clinic

## Treatment Waiver & Informed Consent

### Please identify any of the following symptoms that you are currently experiencing:

- ☐ Severe or persistent bleeding from anywhere
- ☐ Severe pain anywhere
- ☐ Depression or suicidal thoughts
- ☐ Chest pain, especially in the center of the chest or when breathing
- ☐ Shortness of breath
- ☐ High fever, especially with chills or shivers
- ☐ Fainting spells or blackouts
- ☐ Recurrent falls without obvious cause
- ☐ Fits or seizures
- ☐ Persistent vomiting, especially with inability to keep down fluids
- ☐ Severe diarrhea, especially if accompanied by vomiting

I, _____**,** acknowledge I may have a potentially serious disorder. I acknowledge that failure to pursue treatment from my primary healthcare provider may involve serious health risks.

I understand that the scope of practice for an East Asian medicine practitioner in the state of Washington includes the following procedures, and I authorize the practitioners at City Acupuncture and Wellness Clinic to perform the following procedures:

- Acupuncture, including the use of acupuncture needles or lancets to directly or indirectly stimulate acupuncture points and meridians
- Use of medical aromatherapy to support resolution of complaints and overall well-being
- Use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians
- Moxibustion
- Acupressure
- Medical Aromatherapy – Use of select, pure essential oils on acu-points
- Cupping
- Dermal friction technique
- Infrared
- Ion Pumping Cords
- Acutonics Tuning Forks
- Dietary advice and health education based on East Asian medical theory, including the recommendation and sale of herbs, vitamins, minerals, and dietary and nutritional supplements
- Breathing, relaxation, and East Asian exercise techniques
- Qi gong
- East Asian massage and Tui na, a method of East Asian bodywork characterized by the kneading, pressing, rolling, shaking, and stretching of the body without intentional spinal manipulation
- Superficial heat and cold therapies

I understand the services and techniques the East Asian medicine practitioner is authorized to provide may not resolve my underlying potentially serious disorder(s). I understand that the side effects of these procedures may include, but are not limited to, discomfort, pain, minor bruising, bleeding, or the possible aggravation of symptoms.

With this knowledge, I hereby authorize City Acupuncture and Wellness Clinic and its practitioners to perform, diagnose, and treat me according to the professional standards of Oriental medicine and their own professional judgment. This authority shall extend to remedying any unforeseen conditions and/or reactions to the aforementioned treatment procedures. Furthermore, I hereby release City Acupuncture and Wellness Clinic and its practitioners from any and all liability that may occur in connection with any treatment procedures.

_____ _____

**Patient Signature** **Date**