The Healing OM

Oriental Medicine, Acupuncture, Yoga…

Dr. Amanda Bouque, AP, CYT

INFORMED CONSENT FORM

By signing below, I do hereby voluntarily consent to be treated with Acupuncture and/or any modality under this scope of practice. I further understand that Acupuncturists in the state of Florida are considered primary healthcare providers, however, care by a licensed medical doctor is highly recommended.

Acupuncture: I understand that acupuncture is performed by the insertion of sterile needles through the skin with or without electrical stimulation which produces a vibration/tapping sensation on the needles or by the application of heat to the skin (or body) at certain point 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 occur. These could include, but are not limited to; local bruising, mild bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop treatment at any time.

Herbs/Supplements: I understand that herbs, minerals, and vitamin supplements may be recommended to me to treat bodily dysfunction and diseases, to modify or prevent pain perception, and to normalize the body's physiological function. I understand that I am not required to take these substances, but must follow the directions for administration and dosages if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to; changes in bowel movements, 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 will stop taking them and contact Dr. Amanda Bouque as soon as possible.**

Injection Therapy: I understand that herbs, vitamins and/or homeopathic remedies that are injected into the skin may be recommended to me to treat bodily dysfunction or disease. I understand that I am not required to accept this procedure, but if I do, I understand that certain adverse side effects may occur. These side effects include, but are not limited to: soreness at site of injection, pain, redness of skin, swelling, minor bleeding and bruising.

Tui-na, massage, cupping, moxabustion: I understand that I may also be offered tui-na, massage, moxabustion and/or cupping therapy to modify or prevent pain perception and to normalize the body's physiological functions. I am aware the certain adverse side effects may occur. These side effects include, but are not limited to, bruising, sore or achy muscles, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable or painful.

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

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 acupuncturist for more detailed information. I give my permission and consent to treatment.

Signature (Guardian/Parent if Minor): _____ Date: _____

Printed Name: _____ For: _____ Patient's DOB: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

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