JADE
MOUNTAIN
MEDICINE

I voluntarily consent to be treated by the practitioners of Jade Mountain Medicine. I understand that acupuncturists licensed in the state of Oregon are not primary care providers.

Acupuncture/Moxabustion: I understand that acupuncture is the insertion of fine needles through the skin and Moxabustion is the application of heat to the skin at certain points on or near the surface of the body. The modalities are employed to treat bodily dysfunction or disease, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects are unlikely but may occur. These may include but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, or the possible temporary aggravation of symptoms existing prior to acupuncture treatment.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of my therapy there is a risk of burning or scaring from its use.

Botanical and Nutritional Medicine: I understand the importance of following instructions for administration and dosage. I am aware that certain adverse side effects are unlikely but may occur. Should I experience any problems, which I associate with these substances, I should discontinue their use immediately and call Jade Mountain Medicine as soon as possible.

Tunia/Shiatsu Massage: If Tuina or Shiatsu massage is administrated as part of my treatment, I understand that there are certain adverse effects that are unlikely but may occur. These include but are not limited to: muscle soreness or achiness and the possible temporary aggravation of symptoms existing prior to the treatment.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered during the course of my treatment. I am aware that there are certain risks which are unlikely but may occur. These include but are not limited to: mild electrical shock, pain or discomfort, or the possible temporary aggravation of symptoms existing prior to treatment.

I understand that I can refuse any therapy at any time, and that these modalities will only be administered with my acknowledgement and verbal consent at the time of treatment.

Signature of Patient or Personal Representative

_____ Date _____

Consent to Treatment Revised 5/2011