

Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by Ashley Quinnell L.Ac. at Harmony Acupuncture Center, LLC. I understand that acupuncturists practicing in the state of Minnesota 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 practitioner. I also understand that if I should become pregnant during the course of treatment, it is my responsibility to notify my practitioner at Harmony Acupuncture Center, LLC. Ashley Quinnell, L.Ac., and Harmony Acupuncture Center, LLC. make no guarantees as to the effectiveness of treatment. Ashley Quinnell is a Licensed Acupuncturist in the state of MN (#1456).

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of single use sterile needles through the skin at certain points on the surface of the body and moxibustion is performed by the application of heat to the skin or just above the surface of the skin 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, swelling, minor bleeding, fainting, nausea, pain or discomfort, nerve damage, broken needle, soreness at the needling site that may last a few days and the possible aggravation of symptoms existing prior to acupuncture treatment. Infection is possible, although Ashley Quinnell, L.Ac., uses Clean Needle Technique, alcohol and single use sterile disposable needles and maintains a safe and clean environment. 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.

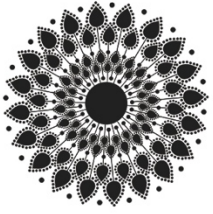
Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must 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 Ashley Quinnell, L.Ac. at Harmony Acupuncture Center, LLC. as soon as possible.*

Acupressure/Tui-Na Massage and Cupping: I understand that I may also be given acupressure/tui-na massage and/or cupping therapy 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, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered 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 practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ **Date:** _____



HARMONY
ACUPUNCTURE CENTER

Ashley Quinnell, L.Ac.
158 Water Street North, Suite 2
Northfield, MN 55057
507.581.1728

Printed Name: _____ Date of Birth: _____

SIGN BELOW ONLY IF YOU REQUESTED AND RECEIVED MORE DETAILED INFORMATION

I requested and received, in substantial detail, further explanation of the procedure or treatment, other alternative procedures or methods of treatment, and information about the material risks of the procedure or treatment. I give my permission and consent to treatment.

X _____
Patient's Signature Date

X _____
Explained by me and signed in my presence Date