Consent to Treatment

I, _____ (Printed Name), hereby authorize Diane Iuliano, L.Ac., M.Ac., Dipl. Ac., to administer any style of Oriental Medicine relevant to my diagnosis and treatment, including but not limited to the following:

1. Insertion of various styles and sizes of acupuncture needles, magnets, zinc and copper pellets on or into my body at various depths and locations.

2. Heat treatment using the herb Arthemesa vulgaris (moxibustion, “moxa”) or a conventional heat lamp may be placed on or near any part of my body. For indirect moxibustion treatments, the moxa is placed on the head of the needle or barrier (such as a cardboard holder or shiunko cream) which rests on the skin. When direct moxa is used, the moxa is placed directly on the skin. The heat generated from moxa treatments may involve a sensation of heat or leave a small blister or scar on the skin. With any type of heat, there is a risk of burn.

3. A massage technique “gwa sha” may produce redness on the skin which remains for 1-5 days. There may be discoloration of tenderness may persist following the treatment.

4. Cupping may be used to promote the circulation of Qi (energy) through the meridians. Cups may produce a red/purple color on the area cupped which may remain for 1-5 days.

5. Electrical stimulation may be used which produces a vibration/tapping sensation on the needles. Ion pumping cords may be attached to the needles.

6. Pediatric Shonishin is a technique of rubbing and tapping acupuncture points and channels on infants and small children. It is used to enhance vitality and immunity, and to treat common pediatric complaints.

7. I have been informed that I have a right to refuse any form of treatment. I understand the nature of the treatment, have been informed of the risks and possible consequences involved with this treatment, and was given an opportunity to ask questions pertaining to my treatment. I also understand there is always a possibility of unexpected complications and I understand that no guarantee can be made concerning the results of the treatment.

Signature of Patient: _____

Date: _____