OXANA GETMAN
CLIENT CONSENT FORM

Please read the following statements and sign below.

- I request and consent to treatment by acupuncture and/or other procedures within the scope of the practice of Traditional Chinese Medicine by a practitioner. Methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, guasha, herbal therapy, tuina massage.
- I am informed that the abovementioned treatment methods are all generally safe but there may be some side effects or risks, as follows:
    - Acupuncture may potentially cause temporary bruising, swelling, bleeding, tingling or soreness at the sight of needling. Unlikely, risks of acupuncture, include lung puncture (pneumothorax), nerve damage, organ puncture, and infection - although, only sterile, disposable needles are used within a clean safe environment.
    - Potential risks of moxibustion, cupping and guasha are temporary bruising, blisters and redness lasting for a few days.
- I will notify the practitioner should I become pregnant or if I am in the process of trying to get pregnant as certain acupuncture points and herbs are contraindicated during pregnancy and could induce miscarriage.
- I understand that I can discuss the risks and benefits further before signing, although I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on my practitioner to exercise her judgement in my best interest during the course of treatment, based upon the facts known.
- I must inform my therapist of any contagious or infectious condition that I might have.
- I understand that I need to express all of my health concerns (both current and past) to my therapist.
- I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatment.
- I understand that if at any time I am not comfortable with, and/or do not understand the purpose of any treatment procedure I will ask the therapist for further explanation/information. I understand that I may stop the assessment or treatment procedure at any time, during or after a session.

If you must miss an appointment, please let this office know at least 24 hours prior to your scheduled appointment. Failure to do so may result in a missed appointment fee equal to the cost of the appointment.

My signature below indicates my understanding of all of the above information.

Client Name (please print) _____ Date:_____

If under 16 years of age, the following section of the consent form must be completed by a parent or guardian before treatment can be initiated.

I have read and fully understand all of the above information and give my permission to have _____ assessed and/or treated by the practitioner.

Parent Signature _____Date:_____