



Informed Consent For Treatment

Pagoda Medicine, LLC
1235 SE Division Street,
Suite 206, Portland, OR 97202

Patients who are pregnant, have a pacemaker or heart condition, those have a seizure disorder or bleeding disorder, or those taking blood thinning medications should discuss these conditions with the acupuncturist before proceeding with any treatments.

By signing below, I do hereby voluntarily consent to the services rendered by Pagoda Medicine, LLC, using treated methods within the scope of practice for licensed acupuncturist as outlined by the Oregon State Board of Medical Examiners. I understand that acupuncturists practicing in the state of Oregon are not primary care providers and that regular care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

I understand that any procedure (acupuncture, electro-acupuncture, massage, moxibustion, cupping, guasha, herbal medicine) intended to help may have complications. While the chances of experiencing side effects are small, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to: soreness, minor bleeding, soft tissue injury, dizziness, bruising, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications is available upon request via the *Adverse Effects Information*. It is also our policy to explain each procedure, including possible risks and alternative treatments. If your practitioner does not explain a procedure to your satisfaction, please ask for more information.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that there is no guarantee for a specific cure or result. I give my permission and consent to treatment.

Signature: _____ Date: _____

Print Name: _____ DOB: _____