



Johnson Chiropractic, Acupuncture, and Oriental Medicine, LLC

22395 US Highway 331 N Paxton, FL 32538 * 850-834-2118

* Dr. Heather Johnson, D.O.M *

Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with chiropractic, acupuncture, other therapies offered by this clinic, and/or substances from the Oriental Materia Medica by a licensed practitioner at Johnson Chiropractic, Acupuncture, and Oriental Medicine, LLC..

While acupuncture has been practiced for thousands of years, and is seen as a safe treatment, there is the chance of risk and this document lists those, as required by law.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body 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, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. 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.

Indirect/Direct Moxibustion: I understand that if I receive Indirect/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 Johnson Chiropractic, Acupuncture, and Oriental Medicine, LLC. as soon as possible.*

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage 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 another health care provider. 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: _____

Printed Name: _____

Date of Birth: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Phone: _____

Patient's Parent (if applicable): _____

Signature: _____

Date: _____