

Dr. Lu's Acupuncture & Massage Clinic, LLC
Yan Lu, DAOM, LAc. Tel: (503) 317-3113. Fax: (503) 459-4709
12732 SE Stark St, Plaza 125, Bldg G, Portland, OR 97233
8283 SW Barbur Blvd, Portland, OR 97219. 503-244-1330
8614 E. Mill Plain Blvd, Ste 310, Vancouver, WA 98664

Consent Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and Oriental medicine. I understand that licensed acupuncturists practicing in Oregon are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended.

ACUPUNCTURE: I understand that acupuncture is performed by the insertion of needles at certain points on the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent perception and to normalize the body's physiological functions.

I have been made aware that certain 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.

ELECTRO-ACUPUNCTURE: I understand that I may be asked to have electro-acupuncture administered with acupuncture, which will increase ACTH and cortisol levels in our bodies naturally to reduce inflammation and pain.

I have been made aware that certain adverse side effects may result which may include, but are not limited to: electric shock, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment.

TUINA/ACUPRESURE/MASSAGE: I understand that I shall also be given tuina massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions.

I have been made aware that certain side effects may result from this treatment. These could include, but are not limited to: muscles soreness and the possible aggravation of symptoms existing prior to the treatment.

CHINESE HERBS: I understand that I shall be asked to take Chinese herbs 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 decide to take them.

I have been made aware that certain side effects 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 Dr. Lu as soon as possible.

SCHEDULED APPOINTMENTS: I understand that if I am unable to make an appointment I should call the clinic that I won't be coming 24 hours before the appointment. Otherwise I will be charged \$15 for missing the appointment.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I have also been asked if I want a more detailed explanation given to me and do not want more information. I give my permission and consent to my treatment.

I understand that no guarantees concerning the use and effectiveness of acupuncture and Oriental medicine are given to me and that I am free to stop treatment at any time.

Signature: _____ Date: _____

Printed Name: _____