CONSENT TO TREATMENT FORM

Traditional Chinese Medicine & Acupuncture

Patient Information:

- Patient Name: _____

Substitute Decision-Maker (if applicable):

- Name: _____
- Relationship to Patient: _____
- Reason patient cannot provide consent: _____

1. VOLUNTARY CONSENT

I, _____ (patient/substitute decision-maker), voluntarily consent to receive Traditional Chinese Medicine (TCM) treatments from:

Practitioner Name: Jason Tarter, R.TCMP, R.Ac
Registration Number: 1762

I understand that I have the right to:

- Ask questions about my treatment at any time
- Withdraw my consent and discontinue treatment at any time without penalty
- Refuse any specific treatment or technique
- Have a chaperone present during treatment

---

2. DESCRIPTION OF SERVICES, TECHNIQUES & PROCEDURES

I understand that the following TCM services, techniques, and procedures may be used during my treatment:

☐ **Acupuncture:** The insertion of sterile, single-use, disposable needles into specific points on the body to regulate the flow of Qi (energy) and promote healing.

☐ **Traditional Chinese Medicine (TCM) Assessment & Diagnosis:** Including tongue and pulse diagnosis, health history review, and TCM pattern differentiation.

☐ **Cupping Therapy:** The application of glass, plastic, or silicone cups to the skin using suction to promote blood flow, reduce muscle tension, and facilitate healing.

☐ **Gua Sha:** A technique using a smooth-edged tool to apply pressure and scrape the skin to improve circulation and release muscle tension.

☐ **Tuina Massage:** A form of Chinese therapeutic massage using various hand techniques to stimulate acupuncture points and meridians.

☐ **Moxibustion:** The burning of dried mugwort (moxa) herb near or on the skin to warm regions and acupuncture points to stimulate circulation and promote healing.

☐ **Other TCM Modalities:** Including but not limited to: herbal medicine recommendations, dietary therapy, lifestyle counselling, electro-acupuncture, heat lamp therapy, and exercise recommendations.

The practitioner has explained these procedures to me in language I understand.

---

3. TREATMENT OF SENSITIVE AREAS - EXPRESS WRITTEN CONSENT

IMPORTANT NOTICE REGARDING SENSITIVE AREAS

I understand and acknowledge that Traditional Chinese Medicine and acupuncture treatments may require contact with or treatment of sensitive areas of the body for legitimate therapeutic purposes. These areas may include, but are not limited to:

- **Chest and breast area** (for respiratory conditions, cardiac issues, rib pain, etc.)
- **Abdomen and lower abdomen** (for digestive issues, reproductive health, menstrual concerns, etc.)
- **Inner thigh and groin area** (for hip pain, sciatica, gynecological/urological conditions, etc.)
- **Gluteal region (buttocks)** (for lower back pain, sciatica, hip conditions, etc.)
- **Upper inner thigh** (for pelvic conditions, knee pain referral, etc.)
- **Lower back and sacral area** (for back pain, reproductive health, etc.)
- **Neck and throat area** (for thyroid issues, throat conditions, etc.)
- **Face and head** (for sinus issues, headaches, facial pain, TMJ, etc.)

PROFESSIONAL AND THERAPEUTIC NATURE OF TREATMENT

I understand and acknowledge that:

✓ ALL CONTACT WITH SENSITIVE AREAS IS STRICTLY THERAPEUTIC AND NON-SEXUAL IN NATURE

✓ Treatment of sensitive areas is based on TCM meridian theory and acupuncture point locations that have been established for thousands of years

1. ✓ The practitioner will only access sensitive areas when clinically necessary and appropriate for my specific condition
2. ✓ The practitioner will explain why treatment of a sensitive area is necessary before proceeding
3. ✓ I will be appropriately draped at all times, with only the area being treated exposed
4. ✓ The practitioner will use professional draping techniques to maintain my privacy and dignity
5. ✓ The practitioner adheres to strict professional boundaries and ethical standards
6. ✓ Any contact is clinical, professional, and performed with therapeutic intent only
7. ✓ I have the right to refuse treatment of any sensitive area at any time
8. ✓ I may request a chaperone be present during treatment of sensitive areas
9. ✓ The practitioner will obtain verbal consent before treating sensitive areas during each session

EXPRESS WRITTEN CONSENT FOR SENSITIVE AREA TREATMENT

I HEREBY PROVIDE MY EXPRESS WRITTEN CONSENT for the practitioner to perform acupuncture, cupping, gua sha, tuina massage, moxibustion, and other TCM treatments on sensitive areas of my body when clinically necessary and appropriate for my condition.

Patient/Substitute Decision-Maker Initials: _____ Date: _____

REFUSAL OF CONSENT FOR SPECIFIC SENSITIVE AREAS

☐ I DO NOT consent to treatment of the following sensitive areas:

CHAPERONE REQUEST

☐ I request that a chaperone be present during treatment of sensitive areas
Patient Initials: _____ Date: _____

☐ I decline the option of having a chaperone present
Patient Initials: _____ Date: _____

ACKNOWLEDGEMENT OF UNDERSTANDING

I acknowledge that I have read, understood, and had explained to me the professional and therapeutic nature of all treatments involving sensitive areas. I understand that all

touch is non-sexual, clinically appropriate, and performed solely for therapeutic purposes.

Patient/Substitute Decision-Maker Initials: _____ Date: _____

---

4. EXPECTED BENEFITS OF TREATMENT

I understand that TCM treatments are intended to provide the following potential benefits:

- Pain relief and management
- Improved circulation and energy flow
- Stress reduction and relaxation
- Enhanced immune function
- Support for various health conditions
- Improved overall health and well-being
- Balance of body systems and energy

---

5. POSSIBLE RISKS, SIDE EFFECTS & CONSEQUENCES

I have been informed of and understand the following possible risks and side effects:

Acupuncture:

- Minor bleeding or bruising at needle sites
- Temporary pain or discomfort during needle insertion
- Dizziness, fainting, or nausea (rare)
- Infection (extremely rare with sterile technique)
- Pneumothorax (extremely rare)
- Temporary worsening of symptoms
- Nerve damage (extremely rare)
- Broken needle (extremely rare)

Cupping:

- Circular bruising or discoloration that may last several days to weeks
- Mild discomfort or skin irritation
- Burns (rare, if heat is used improperly)
- Blistering
- Skin infection (rare)

Gua Sha:

- Temporary redness, bruising, or skin discoloration (petechiae)

- Mild tenderness or soreness
- Skin irritation
- Bruising that may last several days

Tuina Massage:

- Temporary muscle soreness
- Bruising or skin sensitivity
- Temporary increase in pain or discomfort
- Soft tissue injury (rare)

Moxibustion:

- Burns or blisters if applied incorrectly
- Smoke sensitivity or respiratory irritation
- Skin redness or irritation
- Allergic reaction to mugwort (rare)
- Scarring (rare)

General Risks:

- Temporary fatigue or emotional release
- Aggravation of symptoms before improvement
- Allergic reactions to materials used
- Lightheadedness or dizziness

---

6. ALTERNATIVES TO TREATMENT & CONSEQUENCES OF NOT RECEIVING TREATMENT

I understand that alternatives to TCM treatment may include:

- Conventional medical treatment
- Physiotherapy or chiropractic care
- Massage therapy
- Pharmaceutical medications
- Surgical interventions
- Osteopathy or naturopathy
- Other complementary therapies
- No treatment

I understand that if I choose not to receive TCM treatment, the following consequences may occur:

- My condition may remain unchanged
- My symptoms may worsen
- I may not experience the potential benefits of TCM treatment

- I may need to seek alternative forms of treatment
- My quality of life may be affected

---

7. HEALTH DISCLOSURE

I agree to inform the practitioner of all relevant health information, including:

I confirm that the health information provided is accurate and complete. I agree to inform the practitioner immediately of any changes to my health status, including new medications, diagnoses, or pregnancy.

Patient/Substitute Decision-Maker Initials: _____ Date: _____

---

8. NO GUARANTEE OF RESULTS

I understand and acknowledge that:

- TCM and acupuncture are not exact sciences
- There is **NO GUARANTEE** of specific results from treatment
- Individual responses to treatment vary significantly
- The number of treatments needed cannot be precisely determined in advance
- Results may be temporary or require ongoing maintenance treatments
- Some conditions may not respond to TCM treatment
- TCM treatments are complementary and not a substitute for necessary medical diagnosis or treatment
- I should continue to see my medical doctor for regular check-ups and medical concerns
- I should inform my medical doctor that I am receiving TCM treatment

---

9. FEES & FINANCIAL RESPONSIBILITY

I understand and agree to the following fee structure:

- Initial Assessment: $165
- Follow-up Treatment: $90
- Extended Treatment (over 15 minutes): $25
- Herbal Consultation: $60

Payment Policy:

- Payment is due at the time of service unless other arrangements have been made
- Accepted payment methods: Debit, Cash, Credit Card, E-transfer

- **Cancellation policy:** Cancellations must be made at least 24 hours in advance or a fee of $90 may be charged. Please see our full cancellation policy.
- **Late arrival policy:** If you arrive more than 15 minutes late to an appointment it will be considered a no-show and a fee of $90 may be charged.
- **Insurance:** I understand that I am responsible for verifying my insurance coverage and submitting claims. The practitioner may provide receipts but does not guarantee insurance reimbursement.

I accept full financial responsibility for all services rendered.

Patient/Substitute Decision-Maker Initials: _____ **Date:** _____

---

10. REFUSAL OF CONSENT

☐ I REFUSE consent for the following specific treatment(s): _____

Practitioner's note on refusal discussion: _____

Patient/Substitute Decision-Maker Initials: _____ **Date:** _____

---

11. ACKNOWLEDGEMENT & AUTHORIZATION

I acknowledge that:

✓ I have read this consent form in its entirety (or it has been read to me)
✓ The practitioner has explained all sections of this form to me in language I understand
✓ I have had the opportunity to ask questions and all my questions have been answered to my satisfaction
✓ I understand the nature of the proposed treatments
✓ I understand the expected benefits, material risks, and side effects
✓ I understand the alternatives and consequences of not receiving treatment

✓ **I understand that all treatment involving sensitive areas is strictly therapeutic and non-sexual in nature**

✓ **I understand that all touch is professional, clinical, and performed solely for therapeutic purposes**

✓ I am providing this consent voluntarily without coercion, misrepresentation, or fraud

✓ I understand I may withdraw my consent at any time without penalty

✓ I understand I may refuse treatment of any specific area at any time

✓ I have been offered the option of having a chaperone present

I hereby authorize the above-named practitioner to perform TCM treatments including acupuncture, cupping, gua sha, tuina massage, moxibustion, and other TCM modalities as clinically indicated, including treatment of sensitive areas when necessary and appropriate.

SIGNATURES

Patient Signature: _____ Date: _____
Printed Name: _____

OR

Substitute Decision-Maker Signature: _____ Date: _____
Printed Name: _____
Relationship to Patient: _____
Authority to Consent: ☐ Parent/Guardian ☐ Power of Attorney for Personal Care
☐ Other (specify): _____

Practitioner Declaration:

I confirm that I have:

- Explained the nature of the proposed treatments in detail
- Discussed the expected benefits, material risks, and side effects
- Reviewed alternatives and consequences of not receiving treatment
- **Specifically explained the therapeutic and non-sexual nature of all treatments involving sensitive areas**
- **Explained draping protocols and privacy measures**
- Answered all questions posed by the patient/substitute decision-maker to their satisfaction
- Obtained informed consent voluntarily without misrepresentation or fraud
- Verified the patient's understanding of this consent form
- Documented this consent discussion in the patient's chart

Practitioner Signature: _____ **Date:** _____
Printed Name: Jason Tarter
Registration Number: 1762

For Office Use Only:
Chart Number: _____ Date Form Completed: _____ Filed by: _____
Form reviewed and updated: ☐ Annually ☐ As needed Last review date: _____

PATIENT COPY PROVIDED: ☐ Yes Date: _____ Provided by: _____