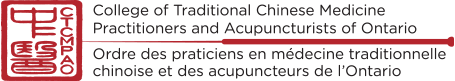
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Joel Farrell R. Ac. Registration # 6963

Member of the:



**Consent to Treatment**

I \_\_\_\_\_\_\_\_\_hereby have been informed of and consent to the performance of acupuncture and other traditional Chinese medicine procedures involving acupuncture and any other practitioner chosen procedure that they believe would benefit the treatment and my health.

I consent that, Joel Farrell R. Ac. who is a registered member of the CTCMPAO, will be allowed to perform these procedures based on the information they are able to gather from my provided history and diagnosis

These procedures or methods may include cupping, gua sha, tui na, bloodletting, heat lamps, exercises, breathing, or suggestions for conduct at home.

I have been informed of the inherent benefits and risks of the treatment and am comfortable with them. I also agree to follow up with the practitioner, other healthcare providers or emergency services as I see appropriate.

I am aware that the practitioner will be gathering and recording personal information based on my health and health history in the interest of creating a diagnosis and treatment.

I understand and accept that it is my responsibility to inform the practitioner of any pregnancy, bleeding disorders, blood borne illness, infectious disease, pacemakers, taking of blood thinners, or have a history of fainting.

I am aware of my ability to waive consent at any given time.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Practitioner Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_