Bellingham Bay Acupuncture PS   Jill A. Likkel EAMP

INFORMED CONSENT TO EAST ASIAN MEDICINE TREATMENT & CARE
East Asian medicine means a health care service using East Asian diagnosis and treatment to promote health and treat organic or functional disorders.

I, the undersigned, hereby request and consent to the performance of East Asian medicine procedures possibly including; **acupuncture**, moxibustion, cupping, plum blossom, dermal friction techniques (gua sha), electroacupuncture, laserpuncture, herbology, infra-red heat, point injection therapy(aquapuncture), sonopuncture, acupressure and dietary advice and health education based on East Asian medical theory, including the recommendation and sale of herbs, vitamins and minerals, dietary and nutritional supplements, breathing, relaxation, and East Asian exercise techniques, Qi Gong, East Asian massage and Tui Na as well as superficial heat and cold therapies, on me (or on the patient named below for whom I am legally responsible) by my acupuncturist, **Jill A Likkel, EAMP, a 1999 Masters of Acupuncture and herbal certificate graduate from the Northwest Institute for Acupuncture and Oriental Medicine, WA license #AC00000550**
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Potential Benefits: drugless relief of presenting symptoms and improved balance of body's energies, which may lead to prevention or elimination of the presenting problem.

Side Effects: May include but not limited to: pain following treatment in the insertion area(uncommon) minor bruising, infection(rare), needle sickness(rare) fainting(rare), and broken needle(rare).

I understand that there are no guarantees regarding cure or improvement of my condition. I understand and am informed that there are some risks to East Asian medicine, such as those listed above. I understand that some herbs may be inappropriate during pregnancy. If I suspect that I am pregnant, I will immediately inform the acupuncturist. If I experience any gastro-intestinal upset or allergic reactions to the herbs, I will inform the acupuncturist. If the patient has a severe bleeding disorder or a pace maker they must inform the acupuncturist

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I hereby release Jill A. Likkel, EAMP. from all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and discontinue participation at any time.

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Signature of Patient or Patient's Representative   Date

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Print Name of Patient and /or Patient's Representative