

**Treatment Consent Form**  
**Heavenly Bodies Clinic: Oriental Medicine & Meridian Therapy**

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

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Tel#(d) (\_\_\_\_\_) \_\_\_\_\_ Tel# (e)(\_\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

I consent to be treated with a Meridian Therapy Modality (Acupuncture, JMT, NMT) by a clinician who is Certified and/or Licensed in Oriental Medicine or Meridian Therapy. The procedure has been explained to me and I understand that certain adverse side effects may result from the treatment. These could include, but are not limited to, a flare-up of my symptoms. Fainting or syncope is rare but may occur when a patient is highly anxious, extremely fatigued or hungry. Other documented side-effects could include, but are not limited to, bruising, swelling, bleeding and soreness which may last an indeterminate amount of time.

I understand that there is no guarantee concerning the effect of the treatment and I know that I am free to discontinue treatment at any time, and that I am responsible for full payment of services provided.

I consent to the release of data from my file in relation to educational and research purposes as long as no personal information is released.

I have carefully read and understand all the preceding and am fully aware of what I am signing.

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Within the last \_\_\_\_\_ months  in the past I have been to a physician \_\_\_\_\_  
Name

For this condition and have received a diagnosis of \_\_\_\_\_

I have been advised to seek consultation and/or treatment in some form of allopathic medicine.

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\_\_\_\_\_  
Patient/Parent Signature Date

\_\_\_\_\_  
Dr. Kathe Ana, L.Ac. Date