REV. DOC. Lisa.
INTEGRAL HEALER

Informed Consent to Treatment for Integral Healing LLC

By signing below *(on page 2),* I do hereby voluntarily consent to treatment by Rev. Dr. Lisa E Graham, Esq. ("Practitioner").

Recommended treatment may include Acupuncture, Electro-Acupuncture, Herbal Therapy, Cupping, Acupressure/Tui Na/Massage, Moxibustion/Infared Therapy, forms of energy work such as Reiki, meditation, Qi gong and other movement therapy and/or nutritional, lifestyle or spiritual counseling.

The disclosures on this form relate to certain therapies and are required by law.

Acupuncture: Acupuncture involves gentle insertion of very fine sterile needles through the skin at certain points on or near the surface of the body to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result which could include (but are not limited to) local achiness, bruising, minor bleeding, tingling, fainting, pain or discomfort, possible aggravation of symptoms existing prior to treatment and extremely rarely, infection, nerve damage or organ puncture. The risk of infection is extremely small as all needles are sterile and my Practitioner practices Clean Needle Technique procedures.

Electro-Acupuncture: Electro-acupuncture involves mild electrical stimulation of inserted acupuncture needles. I understand that certain rare but possible adverse side effects may include (but are not limited to) pain or discomfort, possible aggravation of symptoms existing prior to treatment and electric shock.

Herbal Therapy: Substances from the Oriental Materia Medica (plant, animal or mineral sources) as well as other supplements (together, "medicinals") may be recommended to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. Medicinals are considered safe and most have very few or no side effects when they are both recommended by a trained herbalist and taken according to instructions. Some medicinals must be prepared for internal consumption or external application. ***If I choose to take medicinals, I agree to follow directions for administration and dosage.*** I am aware that certain adverse side effects may result including (but not limited to) changes in bowel function, abdominal pain/discomfort, nausea, vomiting, rashes, hives, tingling of the tongue, as well as possible aggravation of existing symptoms. ***Should I experience any unanticipated or unpleasant effects which I associate with medicinals, I agree to suspend taking them and to contact my Practitioner immediately.***

Cupping: Cupping is the ancient Chinese practice of applying a cup to the skin and reducing the air pressure within it (using heat or air suction), so the skin and superficial connective tissue/muscle layer is drawn into and held briefly in the cup. I understand that there may be bruising over the application area which will resolve within a few days.

(continued on reverse).

Acupressure/Tui-Na Massage: I may also be given acupressure/tui-na massage to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result including (but not limited to)bruising, sore muscles or aches, and possible aggravation of symptoms existing prior to treatment.

Moxibustion/Infrared Therapy: I understand that if I receive moxibustion and/or infrared heat, there is a risk of burning or scarring.

I have been informed that while the modalities utilized by my Practitioner are effective in many instances, they cannot successfully and completely treat all health problems and may not have the results that I expect. I do not anticipate my Practitioner to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on her exercise of judgment during the course of treatment, based upon the facts known, to act in my best interests. I have been given no guarantees regarding treatment and effects.

To the best of my knowledge, I have answered all questions asked of me truthfully. I have had enough time to discuss my condition and proposed treatment with my Practitioner, and all of my questions have been answered to my satisfaction. I believe I have enough information to make an informed decision and consent to treatment. I understand that I may ask additional questions at any time.

I understand that I may refuse any or all treatment at any time.

PREGNANCY*: I understand that it is very important to inform my Practitioner* ***IMMEDIATELY*** *if I am or might be or become pregnant, and I agree to do so.*

My signature below indicates that I have carefully read (or have had read to me) and understand all of the above information and am fully aware of what I am signing.

I hereby provide my informed permission and consent to treatment.

Patient Name: _____ Date: _____

Patient Signature: _____

Responsible Party (parent, guardian or translator, if any):

Name: _____ Date: _____

Signature: _____