Sherrie Brooks, L.Ac.
859 Mosher Avenue
Roseburg, OR 97470

I, ____________________________________, voluntarily consent to be treated with Traditional Chinese Medicine by Sherrie Brooks, L.Ac. ( License Number 160 ), licensed by the Oregon Board of Medical Examiners, and certified by the National Commission for the Certification of Acupuncturists.

I understand that the acupuncture will be performed by the insertion of sterile disposable needles through the skin, or by the application of heat or electric stimulus to the skin at certain points on my body. I understand this treatment is intended to improve body function and/or relieve pain. I understand that Chinese herbal medicine and massage therapy will be used, as appropriate within the Acupuncturist's discretion and scope of practice, as a part of my treatment.

I have been informed that, although rare, certain side effects may result from my acupuncture treatment. These could include, but are not limited to, some localized bruising, bleeding, fainting, some minor pain or discomfort and temporary aggravation of pre-existing conditions.

I accept that no guarantee is made concerning the results of my acupuncture treatment and I have been informed that I may stop acupuncture treatment at any time. I will communicate my reasons for discontinuing treatment with my acupuncturist.

None of the foregoing provisions shall prevent the administration to me of more conventional medical treatment by a licensed physician when, in his or her discretion, such treatment is deemed appropriate.

I will continue to dialogue with the Acupuncturist, raising any questions or concerns I may have, so that I will maximize the benefits of my health care.

I have read the above consent and understand the content.

**Patient or Guardian:** ________________________________________________________

**Date:** ____________________________