Kristen Carroll Gilbert, L.Ac.
Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture, reiki, and/or substances from the Oriental Materia Medica and by licensed acupuncturist and Reiki Master Kristen Carroll Gilbert, L.Ac. I understand that acupuncturists practicing in the state of New York are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt 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. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Cupping/Gua sha: I understand that if I receive cupping or gua sha, there may be bruising and redness in the area where it was preformed. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call Kristen Carroll Gilbert, L.Ac, at 233-2077, as soon as possible.*

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

Reiki: I understand that the purpose of Reiki is relaxation and stress reduction. I understand that during a Reiki treatment, hands will be placed in a series of positions hovering above or lightly touching my body.

I assume full responsibility for my own health and for the results of any session provided by Kristen Carroll Gilbert, L.Ac, that may affect my health in any way. I release Kristen Carroll Gilbert, L.Ac from all legal liability during my participation in sessions with her. All information received by me from Kristen Carroll Gilbert, L.Ac is accepted with full knowledge that any action taken by me as a result of the information received is my complete responsibility. I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ **Date:** _____

Printed Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____

State: _____ **Zip Code:** _____

Phone: _____ **Email Address:** _____