TRADITIONAL AGNIKARMA PATIENT CONSENT FORM

Clinic Name: _____ Date: _____
Doctor Name: _____
Patient Name: _____

Consent to Undergo Traditional Agnikarma

I, the undersigned, hereby consent to undergo Traditional Agnikarma therapy as part of my Ayurvedic treatment at the above-mentioned clinic. I understand that this procedure involves the application of controlled heat to specific areas of the body to provide therapeutic benefits.

Acknowledgment of Information

1. **Therapy Purpose:**
    - I understand that Traditional Agnikarma is a cauterization procedure aimed at relieving pain, improving joint mobility, and treating musculoskeletal disorders.
2. **Procedure and Potential Benefits:**
    - I have been informed about the procedure, its potential benefits (e.g., pain relief, improved function, and reduced inflammation), and its role in maintaining overall wellness.
3. **Possible Risks and Side Effects:**
    - I am aware of possible side effects, such as mild burns, temporary redness, slight discomfort, or minor scarring, and understand that these are generally rare and manageable.
4. **Precautions Taken:**
    - I have disclosed all relevant medical information, including any skin conditions, allergies, or other health concerns, to the attending doctor.
5. **Voluntary Participation:**
    - I confirm that I am undergoing Traditional Agnikarma voluntarily and understand that I may discontinue the session at any time.

Declaration

By signing below, I acknowledge that I have read and understood the information provided about the Traditional Agnikarma therapy. I have had the opportunity to ask questions, and my concerns have been addressed to my satisfaction. I consent to receive the therapy under the care of the attending doctor at the above-mentioned clinic.

Patient Signature: _____
Date: _____
Doctor Signature: _____
Date: _____
Witness (if applicable): _____
Date: _____