Ear Seeding
CLIENT CONSENT FORM

Name _____

Phone _____ Email _____

☐ Check here if you'd like to receive the PurePoint Wellness monthly email newsletter.

Purpose of Ear Seed Treatment

Please initial indicating you have read and understand the 5-point AcuDetox acupressure protocol.

The purpose of this 5-point auricular acupressure (ear seed) protocol is to support nervous system regulation, helping to reduce stress and promote physiological balance.

_____ Hypoallergenic titanium beads with latex-free adhesive are used for this application.

Informed Consent

Please initial you have read and understand the possible adverse effects of ear seeding.

Sometimes after ear seeding you may notice tenderness or swelling around the ear point where the ear seeds are placed. If this becomes extremely uncomfortable, remove the ear seeds. Occasionally small scabs can form under the ear seed,

_____ which will heal quickly on their own and are not a cause for concern.

Ear seeds should be removed after 5 days or immediately in the event of extreme soreness, swelling, scabbing or other

_____ discomfort.

Consent to Ear Seeding Treatment

Please sign after you have read and agree to consent to ear seeding treatment policy.

My signature authorizes PurePoint Wellness to treat me (or the client for whom I am legally responsible) with auriculotherapy using ear seeding. I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on the ear seeding practitioner to exercise judgment during the course of the procedure which the practitioner feels at the time, based on the facts known, is in my best interests. I understand that individual results may vary. I intend for this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature _____ Date _____

PurePoint Wellness
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