

Barbara Ricotta, Licensed Acupuncturist
Mailing address: PO Box 6299, Incline Village, NV 89450
Office address: 8611 N. Lake Blvd, Suite 200 Kings Beach, CA 96143
775-750-7619

INFORMED CONSENT TO ACUPUNCTURE TREATMENT AND CARE

Patient's name (print) _____

I hereby request and consent to the performance of procedures on me (or on the patient named above, for whom I am legally responsible) which are within the scope of practice of oriental medicine including, but not limited to, history-taking, physical and energetic assessment, acupuncture, direct or indirect moxibustion, oriental forms of bodywork including Cranio-Sacral Therapy for meridian balancing, use of topical herbs and oils as well as herbal prescriptions (when indicated) by Barbara Ricotta, Licensed Acupuncturist.

I have had an opportunity to discuss with the acupuncturist the nature and purpose of acupuncture. I understand that results are not guaranteed. I understand and am informed that in the practice of acupuncture there are some risks to treatment, including, but not limited to, bruising, tingling or soreness near the needling sites that may last a few days. There have been instances reported of fainting, infections and scarring. There have also been instances reported of spontaneous miscarriage and pneumothorax.

I understand that some herbs and acupuncture points may be inappropriate during pregnancy and I will inform the acupuncturist of any possibility that I might be pregnant.

I will notify the acupuncturist if I take steroids or anti-coagulants or if I have an implanted pacemaker or a prosthetic heart valve.

If I experience any gastrointestinal upset or apparent allergic reactions to an herbal prescription, I will stop taking the herbs and inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the treatments, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I come to this office to seek treatment.

X _____ / ____ / ____
Signature of patient **date** Signature of Acupuncturist _____ / ____ / ____
date

If patient is a minor or is unable to sign:

Patient's name: _____

Name and relationship of patient representative _____

X _____ / ____ / ____
Signature of representative date