Julia Urcis, L.Ac. 103 Providence Mine Rd. Suite 103 B Nevada City, CA 95959 artebotanical@gmail.com

Informed Consent Agreement

I willingly request and consent to treatment provided by the practitioner stated below, acupuncture and associated therapies with the practice of acupuncture on me or on the person for whom I am legally responsible, whose name is stated below.

I concede to the therapies that may include, but are not limited to, acupuncture, moxibustion, cupping, traditional Chinese medical massage, gua sha (Chinese therapeutic scraping), Chinese herbal prescriptions, and nutritional and lifestyle counseling. I understand that herbs may need to be prepared and decoctions and consumed according to instructions provided orally and in writing. The herbs may not be agreeable to me in odor or taste, but I will at least give them a try. I will immediately notify a member of the clinic staff of any unanticipated or unpleasant effects associated with the consumption of the herbal formula. I will keep the clinic staff informed of any pharmaceutical drug or nutritional supplement, which I have been prescribed, or I am taking, in order to allow proper timing and dosage of Chinese herbal prescriptions. I will notify the clinic staff member who is caring for me if I am or become pregnant.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last several days, and dizziness or fainting. I acknowledge that skin-discoloration is a potential side effects of cupping or gua sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, (including lung puncture, aka. pneumothorax) which could lead to death. Infection is another possible risk, although the clinic uses sterile, single-use, disposable needles and maintains a clean and safe environment. I am aware that burns and possibly even scarring are risks of moxibustion and cupping. I understand that while this document describes the most common adverse effects of treatment, other risks may be present and side effects not listed here may occur. The herbs and nutritional supplements (which are from plant, mineral, and less commonly animal sources) that have been recommended are traditionally considered safe in the practice of Chinese medicine, although some may be toxic in extreme doses. I understand that some herbs may be inappropriate during pregnancy and certain health conditions like hemophilia. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I will notify the clinic staff member who is caring for me if I am or become pregnant or I become aware of a condition that might put me at risk for more adverse effects.

I assume all possible risk to adverse effects of treatment by the practitioner treating me and do not expect the clinical staff to anticipate or explain all possible risks and complications of treatment. I understand that the practitioner, by Hippocratic oath, will perform the therapies in my best interest at any given time during the course of treatment, and I willingly concede to their judgement if they decide that such therapies are not in my best interest. I do not hold the practitioner accountable for the results of our sessions together, and I see myself as an active participant in my recovery to health. I am aware that not all bodies respond to acupuncture or the associated therapies congruently and that no outcome is guaranteed.

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I transparently agree to the use of my patient reports and lab records by the clinical and administrative staff of the practitioner. I am aware that I may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By willingly signing below, I show that I have read, or have had read to me, the consent to treatment and implied risks to acupuncture and related therapies, and have had an opportunity to ask questions.

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 seek treatment from this clinical agency.

_____ _____

Patient Signature (or legal guardian) Printed name (Indicate relationship to patient)

Date:

Provider _____Julia Urcis L.Ac._____