VB Acupuncture

Informed Consent Form

I hereby voluntarily request and consent to be treated with acupuncture and other techniques associated with the practice of Traditional Oriental Medicine by Veronica Bogomazova L.Ac. I understand that methods of treatment may include but are not limited to acupuncture, acupressure, moxibustion, cupping, electrical stimulation, and bodywork therapies such as Tui Na (Chinese Medical Massage). Diet/lifestyle and/or nutritional recommendations may be provided and it is my decision whether or not to follow these recommendations. I understand I have the right to refuse any treatment or procedure.

Possible Side Effects/Healing Reactions

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including local bruising, numbness or tingling near the needling sites that may last a few days, dizziness or fainting, temporary pain or discomfort, and temporary aggravation of symptoms existing prior to treatment. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Bruising is a common side effect of cupping. I understand that I should not move while the needles are being inserted, retained, or removed.

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

Medical Referral

I understand that I should consult a licensed physician for appropriate medical evaluation and treatment of the conditions for which I am seeking acupuncture treatment. Treatment from this practitioner is not a substitute for appropriate medical treatment by a licensed physician. I have been advised that if there is a worsening of my ailment or condition, or if it does not improve within the time estimated by the acupuncturist at the beginning of treatment, or if a new ailment or condition arises, I should again consult a licensed physician. If I am presently under the medical care of a physician, I have been advised to continue all medications and treatments as prescribed until such time as my physician deems it appropriate to reduce or discontinue the medications or treatments. I certify that I have informed Veronica Bogomazova L.Ac of all known physical, mental, and medical conditions and medications, including possible pregnancy, and that I will notify the practitioner of any changes.

Infectious Disease/Clean Needle Procedures

I understand that there is infectious disease carried through the air, through physical contact, and through body fluids. I understand that universally prescribed precautions will be utilized during treatments to guard against the spread of infection, including the use of sterile, prepackaged disposable needles. Needles that are used for my treatment are used only on me, and are inserted according to clean procedures based on nationally prescribed standards. Needles are disposed of as medical waste immediately after use. I understand that my questions about the safety of any procedure or treatment or the precautions taken by the practitioner are most welcome and will be answered as fully as possible.

Privacy

I understand that all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below I show that I have read about the risks and benefits of acupuncture and other procedures, 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.

Print Name: _____ Signature: _____ Date: _____

Practitioner: Veronica Bogomazova L.Ac