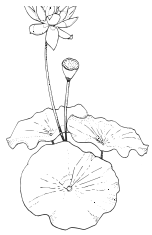

Carol Conigliaro, Licensed Acupuncturist
P.O. Box 912
Lyons, CO 805f40
303-819-2713

Informed Consent to Health Care

I hereby request and consent to the performance of acupuncture and other procedures (cupping, electrical stimulation, massage, moxibustion) within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Carol Conigliaro, L.Ac.

I understand that although acupuncture and other oriental medical procedures have helped millions of people no guarantee for cure or improvement in my condition is given or implied and I am free to stop treatment at any time.

I realize that acupuncture may be considered as an investigative procedure in the United States. I understand and have been informed that there are some possible risks to treatment, including but not limited to minor bleeding, bruising, fainting, possible aggravation of symptoms, pneumothorax (puncture of the lung) and burns. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications during the course of the treatment. I wish to rely on the acupuncturist to exercise her judgement during the course of treatment based upon the facts then known and believe she is acting in my best interest.

I have read, or have had read to me the above consent. I also have 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 conditions for which I seek treatment.

The following is to be completed by the patient or by the patient's representative if the patient is a minor or physically or legally incapacitated.

_____ _____

print name of patient | print name of patient representative

_____ _____

signature of patient | signature of patient representative

_____ _____

date signed | relationship of patient's representative