Healing Acupoints, PLLC

Information provided on this form is confidential. It is very important the information given is complete and accurate to assist you properly in your healing process.

Today's Date ___/___/___

Name _____ Date of Birth ___/___/___ Age:_____ Sex:

Address_____

City/ State/ Zip _____ email _____

Telephone: (home)_____ (work)_____ (cel) _____

Emergency Contact Person/Relationship_____

Phone #_____

Who is your Primary Care Physician ? _____

Referrals are the best compliments. Whom may we thank for your referral ?

What are the concerns for which you are seeking care ? (symptoms, diagnosis and date of onset)

1. _____
2. _____
3. _____

What other treatments have you received for any of these conditions? _____

What makes your condition better ? (movement, rest, heat, cold, eating, sleeping, crying, screaming, etc)_____

What makes your condition worse ? (fatigue, stress, certain foods or times of day, heat, cold, hunger, etc)

_____

**Significant Trauma, Hospitalizations, Surgery, X-Rays, Special Studies**

Please include accidents, falls, illness as well as emotional along with month/year

_____

_____

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**Allergies**

Are you hypersensitive or allergic to any food, drugs, chemical or environmental substances?

_____

**Medications and Supplements**

What medications (prescribed or over the counter) herbs, vitamins, supplements, etc. are you currently taking ?

_____

_____

_____

Check each that you currently use :

| | | | |
|---|---|---|---|
| Laxatives | Pain Relievers | Antacids | Cortisone |
| Antibiotics | Heart/Blood medication | Allergy Medication | Thyroid medication |
| Sleeping Pills | Anti-Depressants | Birth Control Pills | Hormones |

**Exercise, Energy and Dietary:**

How much exercise per week_____Length of workout _____ Activities _____

How is your energy level ?_____When is it lowest ?_____Highest?_____

Typical Diet

Meals per day # of Snacks Caffeinated Drinks Alcohol per week

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

What foods are your weakness?_____

Water intake per day _____Prefer warm or cold drinks _____

Excessively thirsty ?_____

Special Diet :_____

**Personal History** Please check any symptoms you have now or ever have had.

Cancer _____ Diabetes_____ Seizures_____

Heart Disease _____ High/Low Blood Pressure_____ Stroke _____

Anemia _____ Kidney Disease _____ Hepatitis _____

Thyroid Imbalance_____ Asthma _____ Eating Disorder_____

Arthritis _____ Ulcer _____ Alzheimers _____

Auto Immune _____ Alcohol/Drug Addiction_____ Chronic Fatigue_____

Blood Clotting Disorder_____ Prolapsed Organ _____ Chronic Pain _____

Do you smoke ? (Tobacco or Marijuana) For how long ? _____ How much a day ?_____

Other serious Health Condition _____

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**Family Medical History** Please check any condition that applies to your immediate family : (M) Mother, (F) Father, (S) Sister, (B) Brother, (GM) Grandmother, (GF) Grandfather

High Blood Pressure _____ Diabetes_____ Heart Disease_____

Cancer _____ Stroke_____ Asthma _____

Seizures _____ Genetic Disorder _____ Infertility_____

Other Serious Condition _____

**Have you had any of the following Childhood Illnesses (check if yes)**

Scarlet Fever ___ Diptheria ____ Rheumatic Fever ____ Mumps _____ Measles ____ German Measles _____

Have you had negative reactions to immunizations ? Yes No _____

**General**

Height _____ Weight _____ lbs.

Weight one year ago _____ lbs. Maximum Weight _____ lbs. When _____

Blood Type _____ Most recent blood pressure reading? _____/_____ Taken when?_____

**Check any symptoms you currently experience and star ones you have had in the past**

| | | |
|---|---|---|
| **GENERAL**<br>____ Poor or Change in Appetite<br>____ Poor Sleep<br>____ Fatigue / Low Energy<br>____ Fevers<br>____ Chills<br>____ Cravings<br>____ Bleed/Bruise Easily<br>____ Night Sweats or Hot Flashes<br>____ Sweat Easily<br>____ Colder than those around you<br>____ Warmer than those around you<br>____ Weight loss or gain<br>____ Libido Low, Med or High<br>____ High Stress | **NOSE AND SINUSES**<br>____ Frequent Colds<br>____ Nose Bleeds<br>____ Sinus Congestion<br>____ Frequent Runny Nose<br>____ Hay Fever<br>____ Sinus Problems<br>____ Loss of Smell<br><br>**IMMUNE**<br>____ Chronic Fatigue Syndrome<br>____ Chronic Infections<br>____ Chronically Swollen Glands<br>____ Slow Wound Healing | **HEAD / NECK**<br>____ Headaches<br>____ Migraines<br>____ Jaw Pain<br>____ Teeth Grinding<br>____ Swollen Glands<br>____ Goiter<br>____ Recurrent Sore Throats/Colds |
| **SKIN**<br>____ Rashes<br>____ Eczema or Psoriasis<br>____ Acne, Boils<br>____ Redness of Skin<br>____ Itching<br>____ Fungal Infections<br>____ Skin Discoloration<br>____ Hair Loss<br>____ Dry Skin/Scalp<br>____ Greasy Hair<br>____ Change in Hair texture<br>____ Night Sweats<br>____ Slow healing ulcerations<br>____ Weak or ridged nails<br>____ Recent Moles | **MOUTH AND THROAT**<br>____ Sore Throat<br>____ Copious Saliva<br>____ Teeth Grinding<br>____ Sore Tongue/Lips<br>____ Gum Problems<br>____ Hoarseness<br><br>**RESPIRATORY**<br>____ Chest Congestion<br>____ Chest Tightness<br>____ Asthma<br>____ Difficulty inhale/exhale<br>____ Phlegm...what color ?<br>____ Cough ___ Wet or ___ Dry<br>____ Coughing Blood<br>____ Bronchitis<br>____ Pneumonia | **NEUROLOGIC**<br>____ Seizures or Tremors<br>____ Paralysis<br>____ Muscle Weakness<br>____ Numbness or tingling<br>____ Easily Stressed<br>____ Vertigo or Dizziness<br>____ Loss of Balance<br><br>**CARDIOVASCULAR**<br>____ Chest Pain or Pressure<br>____ Shortness of Breath<br>____ Irregular Heart Beat<br>____ Palpitations at Rest<br>____ Blood Clots<br>____ Irregular Heart Beat<br>____ Palpitations/ Fluttering<br>____ Swelling of Hands or Feet |

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**EYES AND EARS**
____ Itchy Eyes
____ Watery Eyes
____ Dry Eyes
____ Swollen/painful eyes
____ Red Eyes
____ Blurred Vision
____ Spots in Front of Eyes
____ Cataracts
____ Color Blindness
____ Double Vision
____ Glaucoma
____ Hearing Difficulty
____ Ringing
____ Earaches/ Infection

**DIGESTION**
____ Abdominal Pain/Cramps
____ Trouble Swallowing
____ Heartburn/Acid Reflux
____ Change in Appetite/Thirst
____ Nausea
____ Vomiting
____ Gas/Bloating
____ Belching or Passing Gas
____ Diarrhea
____ Constipation
____ Pain or Cramps
____ Mucous in Stools
____ Black/Bloody Stool
____ Hemorrhoids
____ Itchy/Burning Anus
____ Bad Breath
____ Strong Smelling Stools
____ Food in Stools
____ IBS
____ Crohns
Bowel Movements : How Often ? ___
Stools ___ Hard ___ Firm
___ Soft ___ Loose (> 2 / day)

**CIRCULATION**
____ Faintness
____ Dizziness
____ Easy Bleeding or Bruising
____ Anemia
____ Deep Leg Pain
____ Varicose Veins
____ Cold hands/feet
____ Spontaneous Sweating

**ENDOCRINE**
____ Hypothyroid
____ Heat or Cold Intolerance
____ Hypoglycemia
____ Diabetes
____ Excessive Thirst
____ Excessive Hunger
____ Seasonal Depression

**MUSCLE / JOINT / BONES**
____ Neck Pain
____ Jaw Pain
____ Shoulder Pain
____ Arm/Wrist Pain
____ Knee Pain
____ Back Pain: Low Middle Upper
____ Sciatica
____ Heaviness of Limbs
____ Muscle Pain/Tension
____ Muscle spasms / cramps
____ Restless Leg Syndrome
____ Weak/Sore Lower Body
____ Areas of Numbness
____ Loss of Strength
____ Tingling Sensations

**GENITO-URINARY**
____ Pain/Burning when urinating
____ Frequent Urination
____ Dark or Pale Yellow
____ Cloudy Urine
____ Night Urination
____ Copious or Scanty Urination
____ Inability to hold Urine
____ Urinary Tract Infections
____ Kidney Stones
____ Blood in Urine

**MENTAL / EMOTIONAL**
____ Mood Swings
____ Anxiety or Nervousness
____ Depression
____ Poor Concentration
____ Poor Memory
____ Angry Outbursts
____ Weepy
____ Sadness

**FEMALE ONLY**
____ Irregular Cycles
____ Bleeding between Cycles
____ Pain during Intercourse
____ Clotting
____ Heavy or Excessive Flow
____ PMS
____ Painful Menses
____ Vaginal Discharge ? Color ?
____ Vaginal Itching/Burning
____ Vaginal Odor
____ Menopausal Symptoms
____ Vaginal Dryness
____ Sexually Transmitted Disease
____ Breast Pain / Tenderness
____ Nipple Discharge
____ Breast Lumps

Are you sexually active? Yes No
Do you practice Birth Control ? Type ?
_____
Have you ever taken the Pill ?
Used an IUD ?

Number of Pregnancies _____
Number of Live Births _____
Number of Miscarriages _____
Number of Abortions _____
Number of Ectopic Pregnancies ____

Difficulty Conceiving _____
Difficult or Premature Births _____
Do you do Breast Self Exams ?
Date of last PAP/Pelvic _____
Abnormal PAP ? When ?

____ Ovarian Cysts
____ Endometriosis
____ Uterine Fibroids/Polyps
____ Polycystic Ovarian Syndrome
____ Pelvic/Tubal Infection
____ Pelvic Inflammatory Disease
____ Pelvic Adhesions/Scarring
____ Chlamydia
____ Herpes
____ Bacterial Vaginosis
____ Genital Warts

**MALES ONLY**
____ Hernias
____ Testicular Masses
____ Testicular Pain
____ Varicoceles
____ STD
____ Premature Ejaculation
____ Prostate Disease
____ Sexually Transmitted Disease
____ Discharge or Sores
____ Sexual Dysfunction

Are you sexually active ? Yes No
Birth Control ? Type?

____ Infertility
____ Semen Analysis Results ?

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**Muscles, Joints & Bones Continued :**

Do you have pain or tightness? Where?_____

Recent injuries? _____ Was this from an auto accident or work related?_____

The pain is (check all that apply): Sharp Dull Aching Numb

Superficial Pain Deep Pain Burning Tingling Shooting

Pain worse/better with heat Pain worse/better with cold Pain worse/better with pressure

Pain worse in am/pm Pain worse/better with movement

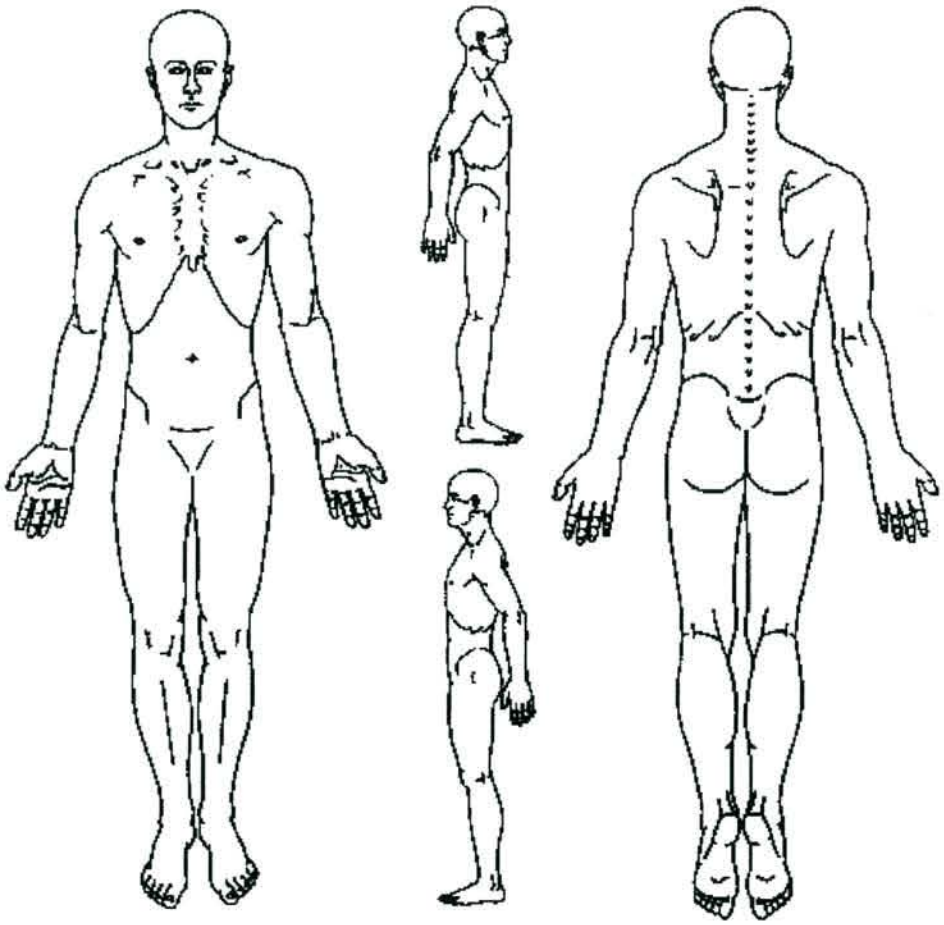
I have (check all that apply): Swollen joints Arthritis/joint pain Tendonitis

Bone pain Muscle cramping Muscle pain Repetitive Strain Injury

Fractured Bone(s) -- Where?_____

Other_____

**Pain Diagram** (please mark all areas of pain on diagram below) A= aching B= burning N=numbness P= pins and needles S= stabbing pain O= other type of sensation



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## Gynecological/Reproductive, continued

Attempting Pregnancy currently? If so, for how long? _____
Currently Pregnant If so, how far along _____ Currently breastfeeding If so, how long?_____ Difficult scanty or painful lactation _____
Post-partum difficulties_____
Describe_____
Premature deliveries _____ Difficult deliveries_____
Describe_____
Difficulties in Pregnancy
Describe_____

_____

_____
Age of first menses_____ What was it like for you?_____
Date of last menses_____ Recent menstrual changes If so, what ?_____
How many days do you normally bleed? _____ How many days between periods? _____
How heavy is the bleeding? Heavy Average Light How many pads/tampons per day?_____
What color is the blood? Pale red, pink Red Dark red Purple Brown Black
Is the blood Watery Clotted Mucousy Thick Strong odor

Painful periods If so, how many days does pain last? _____ What makes the pain better?_____ Heaviness or pressure in pelvis with periods
Have you ever gone more than 2 months without getting your period? When?_____
PMS What symptoms_____ When do they start?_____
Bleeding/Spotting between periods When in cycle _____
Do you ovulate regularly?_____ If so, on what day of your cycle?_____ Is ovulation painful?____ Do you observe cervical mucus changes with ovulation?_____ Bleeding with ovulation?_____
Do any of your symptoms seem to change or worsen around you period?
How?_____ Menopausal Symptoms
Describe_____

_____

_____

**Sleep**

How long do you normally sleep? _____ hours per night
I have difficulties with (check all that apply): ____Falling asleep ____ Staying asleep
____Dream-disturbed sleep _____Waking up at about _____am/pm and not being able to fall back asleep

**Emotional Health**

Have you ever been treated for a psychological concern? Yes No
Have you experienced sexual or physical abuse? Yes No
Have you ever considered or attempted suicide? Yes No
Have you ever been treated for substance abuse? Yes No
Please rate your overall stress level. Low Medium High

Are you currently working with a counselor? If so, who?_____ If possible, please describe the most challenging emotion you experience_____
When do you most often feel this emotion?_____
What experiences or activities bring you the most joy and nourishment?_____

_____
What goals do you have for your acupuncture treatments?_____

_____

Comments: Please describe anything else you would like to discuss. _____

_____

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# Form to be completed by Patient, notifying the Acupuncturist of Whether He/She has been evaluated by a Physician, and other Information

(Pursuant to the requirements of '183.6(e)' of this title (relating to Denial of License; Discipline of Licensee) and Tex. Occ. Code Ann., '205.351, governing the practice of acupuncture.)

I (patient's name) _____, an notifying the acupuncturist (practitioner's name) _____ of the following:

_____ Yes _____ No

I have been evaluated by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed. I recognized that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

_____ (initials of patient) Date: _____

_____ Yes _____ No

I have received a referral from my chiropractor within the last 30 days for acupuncture. After being referred by a chiropractor, if after 120 days or 30 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me t a physician. It is my responsibility and choice whether to follow this advice.

Signature _____ Date _____

Note:

**Exemptions** according to **Rule 183.6 (e) Scope of Practice**

3) …an acupuncturist holding a current and valid license may without an evaluation or a referral from a physician, dentist, or chiropractor perform acupuncture on a person for **smoking addiction, weight loss, alcoholism, chronic pain, or substance abuse.**

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**HIPPA Notice**
**Privacy Disclosure and Policies**

As a patient at this clinic, you have the right to know how your private, confidential healthcare and personal information is being protected. Below are the methods in which your information is secured confidentially in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). This notice describes the policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

***Safeguards in place include:***

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

**Public Interaction**

Should we see you socially, by coincidence or intent, we will not acknowledge how we are acquainted unless you infer consent through introduction, etc.. It is our preference to discuss your health in the office setting only to protect you privacy and ensure that important information is kept in your chart.

**Consultations**

We consult with other healthcare practitioners and clinical specialists while working on patient cases and treatment plans. These conversations and transfers of information by phone, in person, by fax, or email are confidential, and names are not used unless necessary and consent is provided from you either verbally or in writing. In administering your health care, we may gather and maintain information that may include these examples of non-public personal information

- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third party administrators (e.g. requests for medical records, claim payment information)

**Records Release**

Your confidential healthcare information is private and cannot be copied and shared with anyone else without your written, signed consent. In some cases, if time does not permit, your verbal approval may be accepted after proper identification is acquired. Copies of released records are sent by mail or fax, and are accompanied by a Confidential Patient Information Cover Sheet if faxed.

**Definition and Penalties to Comply**

Protected health information is any information, whether oral or recorded, in any form or medium that: 1) is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearing house in the normal course of business, and 2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual. This information may reside in any medium: tape, paper, disc, fax, email, and/or digital voice message.

**I have read and understand my right to privacy, as stated above, and agree to have Seema Sharma, Licensed Acupuncturist maintain my records confidentially in accordance with the law. I agree to inform Seema Sharma, Licensed Acupuncturist if I need any special arrangements pertaining to this issue.**

| signature | date |
|---|---|
| print name | |

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# COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

***To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided)*** **Initial Below**

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. _____
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary. I understand there are alternatives to receiving this care, which could including receiving care from another type of provider, or postponing care altogether at this time. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. _____
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. _____
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:
  *Fever *Dry Cough *Sore Throat
  *Shortness of Breath *Runny Nose *Loss of Taste or Smell _____
- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. _____
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____
- I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

| | | | | | |
|---|---|---|---|---|---|
| Patient Signature: | _____ | Parent / Guardian Signature | _____ | Witness Signature | _____ |
| Name | _____ | Name | _____ | Name: | _____ |
| Date | _____ | Date | _____ | Date: | _____ |

FINANCIAL POLICIES

Healing Acupoints, PLLC request payment for your treatment at the time of service.

Cash or check payments are preferred but we also take VISA, MasterCard and American Express.

I authorize the release of medical information necessary to process my claims. Initial _____

Returned Checks. If your check is returned for insufficient funds, there will be a $25.00 Returned Check fee added to your account, in addition to the amount the check was for. Initial _____

Nonpayment. If your account is over 90 days past due from our first billing sent to you, it will be referred to a collection agency for payment. By signing this agreement you will also authorize the office to release information needed to secure payment. Initial _____

Missed Appointments. If you miss your appointment or cancel with less than 24 hours notice, you will be charged for the appointment. Initial _____

I have read and understand the policies and agree to abide by the guidelines.

_____ _____

Signature of patient or responsible party Date

Thank you for understanding our policies. Please let us know if you have any questions.

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# ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

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 a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff 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 voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told 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.

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

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# INFORMED CONSENT FOR CONSTITUTIONAL FACIAL ACUPUNCTURE

## (Acupuncture Facial)

**INSTRUCTIONS** - This is an informed consent document that has been prepared to help your acupuncturist inform you concerning facial acupuncture treatments, the risks involved, and possible alternatives. Please be advised that this is not a surgical procedure. It is important that you read this information carefully and completely. Please initial each page, indicating that you have read the page and sign the consent for facial acupuncture treatments, as proposed by your acupuncturist.

**INTRODUCTION** - An acupuncture facial treatment involves the insertion of acupuncture needles into fine lines and wrinkles on the face and neck in order to reduce the visible signs of aging. In Oriental medicine, the meridians or pathways of *Qi* (energy) flow throughout the entire body from the soles of the feet up to the face and head; consequently, a facial acupuncture treatment addresses the entire body constitutionally, and is not merely "cosmetic." An acupuncture facial involves the patient in an organic, gradual process, that is customized for each individual. It is no way analogous to, or a substitute for, a surgical "face lift". A treatment session may confine itself solely to facial acupuncture, or it may be used in conjunction with other procedures.

**BENEFITS** - Facial acupuncture can increase facial tone, decrease puffiness around the eyes, as well as bring more firmness to sagging skin, enhance the radiance of the complexion, and flesh out sunken areas. Customarily, fine wrinkles will disappear, and deeper ones be reduced. As this treatment is not merely confined to the face, but incorporates the entire body and constitutional issues of health.

**ALTERNATIVE TREATMENT** - Improvement of sagging skin, wrinkles and fatty deposits may be attempted by other treatments or surgery such as a surgical facelift, chemical face peels, or liposuction. Risk and potential complications are associated with these alternative forms of treatment.

**RISKS OF AN ACUPUNCTURE FACIAL** - Every procedure involves a certain amount of risk and it is important that you understand the risks involved with an acupuncture facial. An individual's choice to undergo an acupuncture facial is based upon the comparison of the risk to potential benefit. Although the majority of patients do not experience the following complications, you should discuss each of them with your acupuncturist to make sure you understand the risks, potential complications, and consequences of an acupuncture facial.

- **BLEEDING** - It is possible, though very unusual, that you may have problems with bleeding during an acupuncture facial. Should post-acupuncture bleeding occur, it will usually only consist of a few drops. Accumulations of blood under the skin may cause a bruise, or *hematoma*, which will resolve itself.
- **INFECTION** - Infection is very unusual after an acupuncture facial. Should an infection occur, additional treatment, including antibiotics, may be necessary.
- **DAMAGE TO DEEPER STRUCTURES** - Deeper structures such as blood vessels and muscles are rarely damaged during the course of a facial acupuncture treatment. If this does occur, the injury may be temporary or permanent.
- **ASYMMETRY** - The human face is normally asymmetrical. Thus, there can be a variation from one side to the other in the results attained from a facial acupuncture treatment.
- **BRUISING AND PUFFINESS** - There is a possibility of bruising (hematomas), puffiness, blood, tingling, itching, warmth, pain or other symptoms at the site of the needle.
- **NERVE INJURY** - Injuries to the motor or sensory nerves rarely result from facial acupuncture treatments. Nerve injuries may cause temporary or permanent loss of facial movements and feeling. Such injuries may improve over time. Injury to sensory nerves of the face, neck and ear regions may cause temporary or more rarely permanent numbness. Painful nerve scarring is very rare.
- **NEEDLE SHOCK** - Needle shock is a rare complication after an acupuncture facial.
- **UNSATISFACTORY RESULT** - There is the possibility of a poor result from an acupuncture facial. You may be disappointed with the results.
- **ALLERGIC REACTIONS** - In rare cases, local allergies to topical preparations have been reported. Systemic reactions which are more serious may occur to herbs used during an acupuncture facial. Allergic reactions may require additional treatment.
- **DELAYED HEALING** - Delayed wound healing or wound disruption are a rare complication experienced by patients in the aftermath of an acupuncture facial. There is a greater risk for smokers, who frequently have dry, sagging skin, which does not heal as readily as that of non-smokers.

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- **LONG TERM EFFECTS** - Subsequent alterations in facial appearance may occur as the result of the normal process of aging, weight loss or gain, sun exposure, or other circumstances not related to an acupuncture facial. An acupuncture facial does not arrest the aging process or produce permanent tightening of the face and neck. Future facial acupuncture maintenance treatments, or other treatments, may be necessary to maintain the results of an acupuncture facial.

**HEALTH INSURANCE** - Most health insurance companies exclude coverage for an acupuncture facial and/or any complications that might occur from an acupuncture facial. Please carefully review your health insurance subscriber information pamphlet.

**ADDITIONAL CARE NECESSARY** - There are many variable conditions in addition to risk and potential complications that may influence the long term result from acupuncture facial treatments. Even though risks and complications occur infrequently, the risks cited are the ones that are particularly associated with an acupuncture facial treatment. Other complications and risks can occur but are even more uncommon. Should complications occur, other treatments may be necessary. The practice of acupuncture is not an exact science. Although good results are expected, there is no guarantee or warranty, either expressed or implied, on the results that may be obtained.

**FINANCIAL RESPONSIBILITIES** - The cost of an acupuncture facial involves several charges for the services provided. The total includes fees charged by your acupuncturist, the cost of acupuncture supplies, and topical preparations. Depending on whether the cost of your acupuncture facial is covered by an insurance plan, you will be responsible for necessary co-payments, deductibles, and charges not covered.

**DISCLAIMER** - Informed-consent documents are used to communicate information about the proposed procedure along with disclosure of risks and alternative forms of treatment(s). The informed consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances. However, informed consent documents should not be considered all-inclusive in defining other methods of care and risks encountered. Your acupuncturist may provide you with additional or different information which is based upon all the facts in your particular case and the present state of knowledge within the field of acupuncture. Informed consent documents are not intended to define or serve as the standard of acupuncture. Standards of acupuncture are determined on the basis of all of the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve. It is important that you read the above information carefully and have all of your questions answered before signing the following consent.

## CONSENT FOR FACIAL ACUPUNCTURE PROCEDURE OR TREATMENT

1. I hereby authorize _____ and such assistants as may be selected to perform an acupuncture facial. I have received the INFORMED CONSENT FOR CONSTITUTIONAL FACIAL ACUPUNCTURE.
2. I recognize that during the course of the acupuncture facial, unforeseen conditions may necessitate different procedures than those above. I therefore authorize the above acupuncturist and assistants or designees to perform such other procedures that are in the exercise of his or her professional judgment necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my acupuncturist at the time the procedure is begun.
3. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.
4. I authorize the release of my Social Security number to appropriate agencies for legal reporting and medical device registration, if applicable.
5. IT HAS BEEN EXPLAINED TO ME IN A WAY THAT I UNDERSTAND:

   A. THE ABOVE TREATMENT OR EXPOSURE TO BE UNDERTAKEN

   B. THERE MAY BE ALTERNATIVE PROCEDURES OR METHODS OF TREATMENT

   C. THERE ARE RISKS TO THE PROCEDURE OR TREATMENT PROPOSED

**I CONSENT TO THE TREATMENT OR PROCEDURE AND THE ABOVE LISTED ITEMS (1-5). I AM SATISFIED WITH THE EXPLANATION.**

_____ _____

**Patient** *(or Person Authorized to Sign for Patient)* **Practitioner**

_____ _____

**Date** **Date**

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