Striving FOR Health

Cosmetic Acupuncture Intake

Name:_____ Date:_____

Address:_____

Home phone number:_____ Cell number:_____

Email address:_____

Occupation:_____ Age:_____ DOB:_____

Emergency Contact:_____ Phone:_____

Primary reason for services today: _____

_____

Have you ever had acupuncture? ____Yes _____No - If yes, what was the nature of the

Treatment (s) and last date of services: _____

How did you hear about us?_____

Would you like to receive our e-newsletter containing health and treatment tips? _____

Medical Info

Please check any of the following health symptoms or conditions:

Abdominal Pain	Diabetes	Muscular Conditions
Allergies	Digestion Issues	Pacemaker
Arthritis	Dizziness	Pain (describe below)
Auto-Immune	Epilepsy	
Blood clots/disorder	Fatigue	Phlebitis
Bruise easily	Headaches	Recent Illness
Cancer	Heart Disease / Problem	Respiratory Issues
Candida	Hepatitis	Skeletal Problems
Chemical Sensitivities	Infection of any type	Skin Problems
Chest Pain	Insulin Pump	Spinal Problems
Circulatory Disorders	Immune Disorders	Seizures
Cold Sores	Joint Pain	Thrombosis
Constipation	Low/High Blood Pressure	Tumors
Decreased skin sensation	Metal Implants	Other (describe below)
Depression	Migraines	

Are you currently taking any of the following medications? Please check.

Accutane	Contraceptives	Laxatives
Antibiotics	Diet Pills	Stimulants
Anticoagulants	Diuretics	Other

List any other medications you may have taken in the past 6 months. Please include hormones and birth control pills:

_____

_____

Are you currently under a physician's care? If so, what are you being treated for?

_____

Your Physician's name:_____ Phone Number:_____

Any major past surgeries, illnesses or accidents? If so, please list.

_____

_____

Any contagious diseases? If so, please list. (ie. HIV, Hepatitis, herpes, etc)

_____

List any vitamins/supplements you take on a regular basis: _____

_____

_____

Are you or do you think that you might be pregnant? _____ Yes _____ No

Lifestyle Info

What is your daily stress level? _____ Low _____ Medium _____ High

What do you do to relieve stress? _____

Do you exercise regularly? _____ Yes _____ No

If "yes", describe the activities and frequency: _____

_____

Do you wear sunscreen? _____ Yes _____ No What is the SPF strength? _____

How often do you consume the following? Please list in the box below.
1= frequently 2 = occasionally 3 = Rarely 4 = Never

Alcohol	Fruits / Fruit Juice	Smoked Foods
Caffeine	Meat	Soda
Dairy	Nuts / Seeds	Vegetables
Fast Food	Processed Foods	Wheat
Fried Foods	Salt	Water

Do you smoke? _____ Yes _____ No If "yes", how much per day? _____

Do you wear contact lenses? _____ Yes _____ No

Do you have a light sensitivity? _____ Yes _____ No

Describe your history with the sun, sunbeds and weather exposure: _____

_____

_____

How many hours of sleep do you get each night? _____

How much water are you drinking each day? _____

Cosmetic Info

Please check any of the items you use regularly:

Cleanser	Eye Make-up Remover	Serum
Concentrate	Facial Oil	Soap
Day Cream	Mask	Sunscreen
Exfoliant	Night Cream	Toner
Eye Cream	Scrub	Other

Do you have any sensitivities to specific products? _____ If yes, please list:_____

_____

Do you use any of the following topical Ointments? Please check.

Alpha Hydroxy	Clindamycin	Retin A
Benzoyl Peroxide	Glycolic Acid	Other

Do you use a particular skin-care or make up line? Which one and what products?

_____

_____

How would you describe the condition of your skin? _____

_____

_____

Have you had facial surgery or cosmetic enhancements? _____ If so, please list procedures and dates:

_____

_____

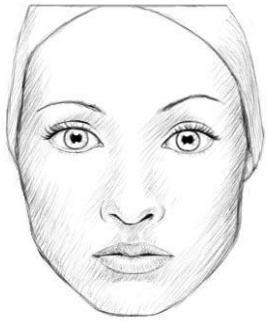
Please check any in-office cosmetic procedures you've received:

Botox	Dermal Fillers	Microdermabrasion
Chemical Peel	Juvederm	Restylane
Cosmetic Tattoo	Laser Hair Removal	Silicone Injections
Dermabrasion	Laser Skin Resurfacing	Other

How often are you getting the procedures above?_____

What areas of the face are you most concerned about and/or which facial skin characteristics would you like to improve? _____

_____



Please indicate and comment on your specific cosmetic concerns or areas that you would like to focus on during treatment. Please be precise and prioritize your concerns.

1._____

2._____

3._____

General Symptoms:

Please indicate the frequency of symptoms where applicable.

D = daily W = weekly M = monthly

Digestion:

___ Indigestion ___ Nervous stomach ___ Bloating ___ Heartburn

___ Nausea/vomit ___ Full feeling/distention ___ Belch/burp ___ Noisy Stomach

___ Pain/cramps ___ Bad Breath ___ Gas ___ Normal

___ Other_____

Perspiration:

___ Very little ___ Easily ___ Night sweats ___ Profuse ___ Bad Smell

___ On palms ___ On feet ___ W/O exertion ___ Normal ___ Other

Bowels:

___ Loose stool ___ Blood in stool ___ Undigested food ___ Bad smell

___ Diarrhea ___ Hemorrhoids ___ Constipation ___ Anus itching

___ Mucus in stool ___ Black stool ___ Hard stools ___ Intestinal worms

___ Use laxatives ___ Colon problems ___ Pellet stool ___ Normal

___Other _____

Urination:

___ Frequent ___ Burning ___ Bladder infection ___ Urgency

___ Night time ___ Blood ___ Incontinence ___ Cloudy

___ Profuse ___ Pus ___ Strong smell ___ Scanty

___ Painful ___ Infection ___ Dark color ___ Norma

___ Other_____

Thirst:

___ Not thirsty ___ Excessive thirst ___ Prefer cold drinks ___ Prefer hot drinks

___ Thirsty but don't want to drink ___ Drink enough every day

Skin:

___ Dry ___ Hives ___ Clammy ___ Oily ___Pimples ___ Rashes

___ Skin tags ___ Itching ___ Warts ___ Eczema ___ Bruises easily ___ Normal

Other _____

Hair:

___ Dry ___ Oily ___ Dandruff ___ Early grey ___ Falling out

___ Normal Other_____

Nails:

___ Soft ___ Spots ___ Grows slowly ___ Pale ___ Breaks easily

___ Purple ___ Ridges ___ Grows fast ___ Lines ___ Normal

Ears:

___ Poor hearing ___ Ear aches ___ Ringing (high pitch) ___ Flaking

___ Discharges ___ Itching ___ Ringing (low pitch) ___ Normal

Eyes:

___ Wears glasses ___ Swollen eyelid ___ Cataract ___ Red ___ Dry

___ Spots in vision ___ Inflammation ___ Glaucoma ___ Itchy ___ Twitch

___ Yellow ___ Poor night vision ___ Sensitive to light ___ Pain ___ Tears

___ Dark Circles ___ Blurry vision ___ Color blindness ___ Strain ___ Normal

___ Other _____

Nose:

___ Stuffy nose ___ Hay fever ___ Sneezing ___Mucus ___Bleeding

___ Loss of smell ___ Sinusitis ___ Itchy nose ___ Dry nose ___ Rhinitis

___ Normal ___ Other _____

Mouth & Throat:

___ Dry ___ Gum problems ___ Frequent sore throat ___ Hoarseness

___ Sores in mouth ___ Hiccups ___ Sores in the mouth ___ Dry lips

___ Swollen glands ___ Grind teeth ___ Sores on tongue ___ Drools a lot

___ Frequent colds ___ Lump in throat ___ Thyroid issues ___ Teeth issues

___ Normal ___ Other_____

Respiratory:

___ Asthma ___ Difficulty inhaling ___Excess sighing ___ Dry cough

___ Chest pain ___ Difficulty exhaling ___ Hx of Bronchitis ___Cough w/mucus

___ Chest tightness ___Difficulty breathing when lying down ___ Cough w/blood

___ Normal ___ Other_____

Cardiovascular - Circulation:

___ Diagnosed Heart issues ___ Palpitations ___ Bleeds easily ___ Chest pain

___ Low blood pressure ___ Murmur ___ Varicose veins ___ Ankle swelling

___ High blood pressure ___ Bruise easily ___ Hx of anemia ___ Facial swelling

___ Broken blood vessels or capillaries ___ High cholesterol ___ Hand swelling

___ Numbness in extremities___ Spider veins ___ Slow heart beat ___ Irr. Heart beat

___ Normal ___ Other_____

Pain:

___ Low back ___ Mid back ___ Upper back ___Hips ___ Torso

___ Neck ___ Spine ___ Hands ___ Wrist ___ Arms

___ Sciatica ___ Legs ___ Knees ___ Ankles ___ Feet

___ Muscle cramps ___ Nerve pain ___ Weak muscles ___ Muscle twitching

___ Normal ___ Other_____

What is the nature of the pain? (sharp, dull, cold, hot, continuous, comes and goes)

_____

What makes it better?_____

What makes it worse?_____

How long have you had the pain?_____

Lifestyle Questions **Please check where applicable.**

Daily or weekly habits:

___ Cigarettes ___ Cigars ___ Soft drinks ___ Fast food ___ Salt

___ Alcohol ___ Caffeine ___ Sugar ___ Coffee ___ Water

___ Daily stress ___ Recreational drugs ___ Other_____

Exercise:

___ Never ___ Little ___ Moderate ___ Heavy

What type of exercise do you do?_____

Emotional state:

___ Happy ___ Angry ___ Sad/Depressed ___ Stressed ___ Restless

___Easily irritable ___ Cry easily ___ Laugh easily ___ Worried ___ Foggy headed

___ Difficulty making decisions ___ Hurry to get things done ___ Overwhelmed

___ Normal ___ Other_____

Appetite:

___ Up and down ___ Poor ___ Good ___ Always hungry ___ Loss of taste

Weight:

___ Under weight ___ Overweight ___ Recent gain ___ Recent loss

___ Can't gain ___ Can't lose ___ Weight gain started after 40 year of age

___ Normal weight ___ Other_____

Energy:

___ Up and down ___ Low ___ Low after eating ___ Excess ___ Normal

___ Tired in the afternoons ___ Tired in the mornings ___ Wake feeling rested

___ Feel exhausted ___ Wake feeling tired ___ Other_____

Stress Level:

___ Not stressed ___ Slightly stressed ___ Very stressed ___ Extremely stressed

Do you have an outlet for your stress?_____

Are you getting any relaxation time during the week?_____ How much?_____

Sleep:

___ Difficulty falling asleep ___ Awaken easily ___ Restless ___ Excessive dreaming

___ Nightmares ___ Always sleepy ___ Tired when getting up in the morning

___ Difficulty going back to sleep if woken ___ Other_____

How much sleep do you get each night?_____

Headache / dizziness

___ Headaches ___ Dizziness ___ Vertigo ___ Migraines ___Motion sickness

___ Poor memory ___ Poor balance ___Faints ___ Nausea

___ Bend down then stand up and get dizzy ___ Other_____

Body Temperature:

___ Warm natured ___ Flushed face ___ Warmer in the afternoon and night

___ Cold natured ___ Warm palms ___Alternate chills and fever

___ Cold hands ___ Cold feet ___ Normal

Diet: Please use 1 check if eaten daily and 2 checks if eaten weekly.

___ Meats ___ Poultry ___ Fish ___ Whole grains ___ Dairy products

___ Soy products ___ Fruits ___ Sweets ___ Fried foods ___ Hot spicy foods

___ Vegetables ___ Salads ___ Fast food ___ Cold food ___ Soft drinks

___Fats/oils ___Caffeine ___ Coffee ___ Chips/snacks ___ Refined grains

___Alcohol ___ Salt ___ Sugar ___ Nuts/Seeds ___Beans/Legumes

Do you crave any types of foods?_____

Do you eat full meals or just snack during the day?_____

What are your favorite foods?_____

What foods do you dislike?_____

Do you have a favorite flavor? ___ Sweet ___ Sour ___ Bitter ___ Salty ___ Pungent

Are you on a specific diet?_____ Why?_____

How much water do you drink each day?_____

Is your diet heavy with any one group of food?_____

How many servings of fruit and vegetables are you getting every day?_____

How are you getting them in your diet? _____

Are they mostly eaten raw or cooked?_____

What are your preferred methods of cooking?

___Steaming ___Boiling ___Baking ___Frying ___Sautéing ___Slow cooker ___Wok

Do you cook at home or eat out more often?_____

How often are you eating out each week?_____

For women only:

Are you currently pregnant?_____ If so, when are you due?_____

Are you currently nursing?_____ If so, for how long?_____

Do you have kids?_____ If so, how many and how old are they?_____

Any complications with the pregnancy?_____

Any complications with the delivery?_____

_____

Any past gynecological surgeries or issues?_____ If so, what were they?_____

_____

What is your normal cycle?_____ Are you taking birth control pills?_____

Please check where applicable.

Menstruation cycle issues (before or after menses):

___ Irregular cycle ___ Painful ___ Heavy flow ___ Scanty flow ___ Diarrhea

___ Clotting ___Cramps ___ PMS Symptoms ___ H2O Retention ___ Sighing

___ Irritable ___ Breast tenderness or pain ___ Constipation ___Bloating

___ Emotional ___ Other_____

Vaginal Discharges:

___ Yellow ___ White ___ Clear ___ Red ___ Thick ___ Thin

Is the discharge only at ovulation?_____ If not, when?_____

Any other symptoms at ovulation?_____

Menopausal symptoms:

When did menopause start?_____ How long did it last?_____

Are you currently experiencing symptoms? _____ Have you had a hysterectomy? _____

___ Hot flashes ___ Night sweats ___ Dry skin ___ Insomnia ___ Irritability

___ Emotional ___ Vaginal dryness ___ Fatigue ___ Anxiety ___ Mood swings

___ Weight gain ___ Depression ___ Other _____

Striving FOR Health

Informed Consent for Treatment

I hereby request and consent to the treatment of acupuncture and any other procedure within the scope of practice of Traditional Chinese Medicine at Striving for Health. I consent to treatment for myself (or for the client named below, for whom I am legally responsible) by DeBritt Ealey, L.Ac. and/or any other licensed acupuncturists who now or in the future may treat me while employed by, working or associated with Striving for Health or serving as back up for DeBritt Ealey at any location.

I understand that methods of treatment within the scope of Traditional Chinese Medicine may include, but are not limited to: acupuncture (treatment with needles), acupressure point stimulation (manual or external device), electrical stimulation (microcurrent), cupping (cups made of plastic or glass placed on the skin forming a suction), Tui-na (Chinese massage), Gua sha (Chinese dermal friction technique), herbal medicine, dietary therapy, cosmetic acupuncture, ear acupuncture point stimulation and/or LED light therapy.

I have been informed that acupuncture is a generally safe method of treatment but that it may have some possible side effects, although rare, that can include: bruising, numbness or tingling near the needle site that may last for a few days, dizziness or fainting, and needle sickness or shock. Most clients do not experience any complications with treatment.

Body and Face Acupuncture/Acupressure/Cupping/Gua Sha:

In very rare instances needles can break. Bleeding or bruising can be a side effect with acupuncture as well as possible nerve injury and needle shock. These side effects are extremely rare, but possible. Bruising is a very common side effect after a body cupping or gua sha treatment. However, there is no bruising after a facial cupping or gua sha treatment. Infection is another low but possible risk, however, this clinic ONLY uses sterilized, single use needles and practices in a clean environment to reduce this chance even further. I understand that while this document describes the major risks of treatment other side effects and risks may occur.

Herbal Therapy:

The herbs and nutritional supplements recommended (which can be from foods, plants, animal and mineral sources) are considered to be very safe within the practice of Traditional Chinese Medicine. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and/or tingling of the tongue. I understand that some herbs may interact with prescription medications, over-the-counter medications, or supplements; therefore, I will notify the acupuncturist

named above if I am taking any medication or supplements concurrently with Chinese herbs. I understand that some herbs may be inappropriate during pregnancy.

Cosmetic Acupuncture or Microneedling Treatments:

All side effect possibilities of acupuncture apply as well as the possibility of asymmetry due to a pre-existing natural asymmetry, previous injuries on the side of the face/body, or severity of symptoms from one side or the other. Direct needling or a microneedling roller may be used, depending on the needs of the patient. If microneedling is done, side effects are minimal but typically include redness, dryness, minor flaking or itching for 24 to 72 hours after the treatment. If the patient experiences cold sore, needling on the face could bring on an outbreak so let us know. During post treatment massage of the face, topical applications of organic products or herbs may be used so there is always a small chance of a local allergic reaction. Sample skin testing of the substance is done prior to application to help decrease this risk. I understand that cosmetic acupuncture results are much slower and less pronounced than with surgical or laser procedures, derma fillers or Botox, therefore I cannot expect the same level of change or the immediate results received from these other therapies.

I understand that everyone responds differently to treatment, no matter what treatment is done, and results may vary. I will notify the acupuncturist and/or clinic if I am or if I become pregnant. Clients with severe bleeding disorders, diabetes, lymph edema, or infectious diseases such as HIV/AIDS, hepatitis, or tuberculosis should inform the acupuncturist prior to any treatment.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist's professional knowledge and judgment to determine and provide the best treatment for me, based upon the facts known at the time of treatment. I understand that results are not guaranteed. I understand that the acupuncturist is not providing Western (allopathic) medical diagnosis or care and that I should look to my Western primary care practitioner (ie:MD) for those services and for routine checkups.

By voluntarily signing below, I acknowledge that I have read or had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures within Traditional Chinese Medicine and have had the opportunity to ask questions about any of this with my acupuncturist. I intend this consent form to cover the entire course of my treatment for my present symptoms and conditions and for any future symptoms and conditions for which I seek treatment.

I also understand that there is a cancelation policy. If I cancel or reschedule my appointment within 24 hours of my scheduled time or don't show up for a scheduled appointment, I will be charged a $75 fee.

Signed_____ Dated_____

Printed Name_____

Authorization to Release Health Information

HIPAA privacy regulations stipulate that health care providers may not use or disclose a patient's health information without his or her authorization, except as described in the Notice of Privacy Practices. That document clarifies the conditions under which a patient's information may be released without his or her authorization, and when an express authorization is required by the patients.

Under certain circumstances, it may become necessary for this office to release a patient's health information to an individual or entity outside of the office. In accordance with the Notice of Privacy Practices, this office via this authorization form, requests that the patients indicate below to authorize the release of his/her health information. This office doesn't accept insurance so the need to have any records released outside of the office is very rare.

I, the undersigned, understand that I have the right to:

- Refuse to sign this authorization
- Receive a copy of the authorization
- Restrict what is disclosed by this authorization
- Inspect or request an amendment of the health information to be disclosed
- Revoke this authorization, by written notice
- Be notified if any records are requested

I recognize that once disclosed, my health information is no longer under the control of this practitioner/clinic. While I understand that the practitioners/clinic will make a good faith effort to release my information only to trusted recipients, my health information may be re-disclosed by subsequent parties, and thus may no longer be protected by this office's privacy practices.

I understand that whether or not I sign this document, it will not affect my treatment at this practice or the payments I incur. If I do experience any such negative repercussions, I have the right to file a complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services. I can find the Office for Civil Right for my state at: http://www.hhs.gov/ocr/regmail.html

I hereby authorize this office (Striving for Health) to disclose my health information as described in this document.

_____ _____

Name of Client Contact Number

_____ _____

Address Email

_____ _____

Signature Date

DeBritt Ealey, L.Ac. | 703.707.7777 office | 512.963.8031 cell
451B Carlisle Dr. Herndon, VA 20170
debritt@strivingforhealth.com | www.strivingforhealth.com

Striving FOR Health

Diagnostic Examination Release

As an acupuncturist licensed in the state of Virginia, it is required that I ask if you have received a diagnostic examination within the past six months by a licensed Doctor of Medicine (MD), Doctor of Osteopathy (DO), or Doctor of Chiropractic (DC) acting within the scope of his/her practice for the issue(s) that we will be addressing in this office.

I have seen a doctor about my issue(s):_____

_____

If not, I am instructed to recommend that you get a diagnostic examination by a licensed Doctor of Medicine (MD), Doctor of Osteopathy (DO), or Doctor of Chiropractic (DC) acting within the scope of his/her practice for the issue(s)that we will be addressing in this office.

I have read and understand this information.

_____ _____

Signature Date

DeBritt Ealey, L.Ac. | 703.707.7777 office | 512.963.8031 cell
451B Carlisle Dr. Herndon, VA 20170
debritt@strivingforhealth.com | www.strivingforhealth.com

American Acupuncture Council Informed Consent for Constitutional Facial Acupuncture

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.
- **Deeper Structures:** Deeper Damage to 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 Results:** 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.
- **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 ___DeBritt Ealey, L.Ac._____ 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**