









































# HEALTH HISTORY FOR FACIAL ACUPUNCTURE

DATE: \_\_\_/\_\_\_/\_\_\_

NAME _____		GENDER _____	AGE _____	DATE OF BIRTH ___/___/___
ADDRESS _____		CITY _____	STATE _____	ZIP CODE _____
PHONE # <input type="checkbox"/> HOME _____ <input type="checkbox"/> CELL _____ <input type="checkbox"/> OTHER _____ EMAIL _____		EMERGENCY CONTACT _____ CONTACT PHONE # _____ RELATIONSHIP _____		
OCCUPATION: _____	HEIGHT _____ WEIGHT _____	PHYSICIAN NAME _____ PHYSICIAN ADDRESS _____ PHYSICIAN PHONE # _____		
HAVE YOU BEEN TREATED BY ACUPUNCTURE OR ORIENTAL MEDICINE BEFORE? <input type="checkbox"/> No <input type="checkbox"/> Yes .... LAST TREATMENT ___/___/___		RELATIONSHIP STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> LIVING W/PARTNER <input type="checkbox"/> OTHER <input type="checkbox"/> SEPARATED		
HOW DID YOU HEAR ABOUT OUR CLINIC? _____				

WHY YOU ARE CHOOSING FACIAL REJUVENATION	OTHER HEALTH CONCERNS
	1
	2
	3

HEALTH HISTORY							
	YOU	YEAR	FAMILY		YOU	YEAR	FAMILY

<input type="checkbox"/> CANCER – TYPE(S) _____		[ ]		<input type="checkbox"/> OSTEOPOROSIS		[ ]	
<input type="checkbox"/> DIABETES		[ ]		<input type="checkbox"/> HERPES		[ ]	
<input type="checkbox"/> HEPATITIS		[ ]		<input type="checkbox"/> AIDS/HIV		[ ]	
<input type="checkbox"/> HIGH BLOOD PRESSURE		[ ]		<input type="checkbox"/> OTHER STD		[ ]	
<input type="checkbox"/> HEART DISEASE		[ ]		<input type="checkbox"/> RHEUMATIC FEVER		[ ]	
<input type="checkbox"/> STROKE		[ ]		<input type="checkbox"/> ALCOHOLISM		[ ]	
<input type="checkbox"/> SEIZURE		[ ]		<input type="checkbox"/> ALLERGIES –TYPES _____		[ ]	
<input type="checkbox"/> THYROID DISEASE		[ ]		<input type="checkbox"/> MENTAL ILLNESS		[ ]	
<input type="checkbox"/> ASTHMA		[ ]		<input type="checkbox"/> KIDNEY DISEASE		[ ]	
<input type="checkbox"/> PACEMAKER		[ ]		<input type="checkbox"/> ANEMIA		[ ]	

HABITS	EXERCISE
AMOUNT/FREQUENCY COFFEE/TEA _____ TOBACCO _____ ALCOHOL _____ DRUGS _____	REGULARLY? <input type="checkbox"/> YES <input type="checkbox"/> NO IF SO, WHAT AND HOW OFTEN: _____

### MEDICATIONS

PLEASE NOTE WHAT MEDICATIONS, HERBS OR SUPPLEMENTS YOU USE REGULARLY

MEDICINE/VITAMINS	DOSAGE	REASON	HOW LONG?

### INJURIES & SURGERIES

PLEASE NOTE AREA OF BODY & DATE


### TEMPERATURE

HOW WARM / COLD YOU FEEL (NOT IN DEGREES) RELATIVE TO OTHER PEOPLE?  
DO YOU WEAR MORE OR LESS LAYERS, ETC.

PLEASE INDICATE YOUR BODY'S OVERALL RELATIVE TEMPERATURE ALONG THE LINE WITH AN **X**

COLD ←————→ HOT

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> COLD HANDS/ FEET    | <input type="checkbox"/> EXCESSIVE THIRST            | <input type="checkbox"/> NIGHT SWEATS   | <input type="checkbox"/> HOT HANDS, FEET, CHEST |
| <input type="checkbox"/> CHILLS              | <input type="checkbox"/> THIRST FOR COLD /HOT DRINKS | <input type="checkbox"/> UNUSUAL SWEATS | <input type="checkbox"/> HOT FLASHES            |
| <input type="checkbox"/> COLD "IN THE BONES" | <input type="checkbox"/> THIRST, NO DESIRE TO DRINK  | WHEN? _____AM / PM                      | <input type="checkbox"/> HOT IN AFTERNOON       |
| <input type="checkbox"/> AREAS OF NUMBNESS   | <input type="checkbox"/> ABSENCE OF THIRST           | WHERE ON BODY _____                     | <input type="checkbox"/> HOT AT NIGHT           |

### MOISTURE

PLEASE INDICATE YOUR BODY'S RELATIVE MOISTURE LEVEL ALONG THE LINE WITH AN **X**  
HAIR, SKIN, MOUTH, ETC.

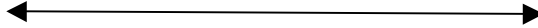
DRY ←————→ OILY

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> DRY SKIN          | <input type="checkbox"/> DRY MOUTH            | <input type="checkbox"/> EDEMA /SWELLING _____ | <input type="checkbox"/> WEIGHT GAIN / LOSS |
| <input type="checkbox"/> DRY HAIR          | <input type="checkbox"/> DRY LIPS             | <input type="checkbox"/> RASHES _____          | <input type="checkbox"/> OILY SKIN          |
| <input type="checkbox"/> DRY EYES          | <input type="checkbox"/> DRY THROAT           | <input type="checkbox"/> ITCHING _____         | <input type="checkbox"/> OILY HAIR          |
| <input type="checkbox"/> DRY BRITTLE NAILS | <input type="checkbox"/> DRY NOSE /NOSEBLEEDS | <input type="checkbox"/> DANDRUFF              | <input type="checkbox"/> PIMPLES            |

## DIGESTION

PLEASE INDICATE YOUR BODY'S OVERALL DIGESTION ALONG THE LINE WITH AN **X**

DIARRHEA ←



→ CONSTIPATION

BM: HOW OFTEN? \_\_\_\_X / EVERY \_\_\_\_DAYS

- ALTERNATING DIARRHEA & CONSTIPATION (IBS)
- INDIGESTION
- GAS
- BELCHING
- BLOATING

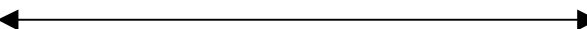
- NAUSEA / VOMITING
- BAD BREATH
- DRY STOOLS
- DIFFICULT TO PASS
- TIRED AFTER BM

- EXCESSIVE HUNGER
- POOR APPETITE
- ULCER
- HEMORRHOIDS

## ENERGY

PLEASE INDICATE YOUR BODY'S OVERALL ENERGY LEVEL ALONG THE LINE WITH AN **X**

LOW ←



→ HIGH

- SUDDEN ENERGY DROP  
TIME OF DAY: \_\_\_\_ AM / PM
- ENERGY DROP AFTER EATING
- FATIGUE
- DEPENDENCE ON CAFFEINE
- WIRED / UNGROUNDED FEELING
- BODY / LIMBS FEEL HEAVY
- BODY / LIMBS FEEL WEAK

- SHORTNESS OF BREATH
- HEART PALPITATIONS
- BLOOD PRESSURE HIGH / LOW
- BLEED / BRUISE EASILY
- HARD TO CONCENTRATE
- POOR MEMORY
- DIZZINESS / LIGHTEADED
- HEADACHES \_\_\_\_X / WEEK

## FEMALE REPRODUCTIVE

ARE YOU SEXUALLY ACTIVE? Y  N

### MENSES (IF APPLICABLE)

AGE AT FIRST MENSES \_\_\_\_  
LENGTH OF FULL CYCLE \_\_\_\_ DAYS  
LENGTH OF MENSES \_\_\_\_ DAYS  
LAST MENSES START DATE \_\_\_\_ / \_\_\_\_  
# OF PREGNANCIES \_\_\_\_  
# OF BIRTHS \_\_\_\_PREMATURE \_\_\_\_MISCARRIAGES  
\_\_\_\_ABORTIONS

- BIRTH CONTROL PILL (HORMONAL)
- HEAVY PERIODS
- LIGHT PERIODS
- PAINFUL PERIODS
- IRREGULAR PERIODS
- CHANGES IN BODY/PSYCHE PRIOR TO MENSTRUATION (PMS)

- CRAMPS BEFORE BLEEDING\_\_\_\_  
FIRST DAY\_\_\_\_DURING PERIOD\_\_\_\_
- FATIGUE W/ MENSES
- DIGESTIVE CHANGES W/ MENSES
- MID-CYCLE SPOTTING
- YEAST INFECTIONS

### MENOPAUSE

AGE CHANGES BEGAN \_\_\_\_  
AGE AT LAST MENSES \_\_\_\_

- HOT FLASHES \_\_\_\_X/ DAY
- VAGINAL DRYNESS
- NIGHT SWEATS \_\_\_\_X / WEEK
- LOSS OF SEX DRIVE

## MALE REPRODUCTIVE

ARE YOU SEXUALLY ACTIVE? Y  N

- CHANGE OF SEXUAL DRIVE
- ERECTILE DYSFUNCTION
- PREMATURE EJACULATION
- SORES ON GENITALS
- DISCHARGE

- PROSTATE DISEASE
- GENITAL PAIN
- JOCK ITCH
- VASECTOMY
- HERNIA
- HEMORRHOIDS

## EMOTIONS

WHAT EMOTION(S) DOMINATE YOUR EXPERIENCE?

- |                                       |   |                                      |
|---------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> ANGER        | <input type="checkbox"/> OBSSIVE THINKING | <input type="checkbox"/> FEAR        |
| <input type="checkbox"/> IRRITABILITY | <input type="checkbox"/> SADNESS          | <input type="checkbox"/> TIMID / SHY |
| <input type="checkbox"/> ANXIETY      | <input type="checkbox"/> GRIEF            | <input type="checkbox"/> INDECISION  |
| <input type="checkbox"/> WORRY        | <input type="checkbox"/> DEPRESSION       |                                      |

## URINARY (IF APPLICABLE)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> DECREASE IN FLOW               | <input type="checkbox"/> KIDNEY STONES      | <input type="checkbox"/> BURNING SENSATION |
| <input type="checkbox"/> DRIBBLING                      | <input type="checkbox"/> URGENCY TO URINATE | <input type="checkbox"/> CLOUDY URINE      |
| <input type="checkbox"/> DIFFICULTY STARTING / STOPPING | <input type="checkbox"/> FREQUENT URINATION | <input type="checkbox"/> BLOOD IN URINE    |
| <input type="checkbox"/> INCONTINENCE                   | <input type="checkbox"/> PAIN ON URINATION  |  |

## SLEEP

# HOURS PER NIGHT \_\_\_\_\_

- |  |   |
|--|---|
| <input type="checkbox"/> DIFFICULTY FALLING ASLEEP               | <input type="checkbox"/> DISTURBING DREAMS      |
| <input type="checkbox"/> WAKE ___X/ NIGHT @ _____AM / PM         | <input type="checkbox"/> RESTLESS SLEEP         |
| <input type="checkbox"/> WAKE TO URINATE <i>HOW OFTEN?</i> _____ | <input type="checkbox"/> NOT RESTED UPON WAKING |

## HEAD, EYES, EARS, NOSE, THROAT

- |   |   |
|---|---|
| <input type="checkbox"/> POOR HEARING       | <input type="checkbox"/> SINUS CONGESTION             |
| <input type="checkbox"/> RINGING IN EARS    | <input type="checkbox"/> NOSE BLEEDS                  |
| <input type="checkbox"/> EXCESS EARWAX      | <input type="checkbox"/> LOSS OF SMELL                |
|   | <input type="checkbox"/> PHLEGM ( <i>COLOR</i> _____) |
| <input type="checkbox"/> SORE THROAT        | <input type="checkbox"/> RED EYES                     |
| <input type="checkbox"/> FREQUENT COUGHS    | <input type="checkbox"/> ITCHY EYES                   |
| <input type="checkbox"/> SWOLLEN GLANDS     | <input type="checkbox"/> TEARY EYES                   |
| <input type="checkbox"/> HOARSENESS         | <input type="checkbox"/> DRY EYES                     |
| <input type="checkbox"/> TROUBLE SWALLOWING | <input type="checkbox"/> CATARACTS                    |
| <input type="checkbox"/> POOR VISION        | <input type="checkbox"/> GLAUCOMA                     |
| <input type="checkbox"/> NIGHT BLINDNESS    | <input type="checkbox"/> SPOTS IN FRONT OF EYES       |
| <input type="checkbox"/> HEADACHE           | <input type="checkbox"/> DENTAL PROBLEMS              |
| <input type="checkbox"/> MIGRAINE           | <input type="checkbox"/> MOUTH SORES                  |
| <input type="checkbox"/> HEAD INJURY        | <input type="checkbox"/> JAW PROBLEMS /TMJ            |
| <input type="checkbox"/> DIZZINESS          | <input type="checkbox"/> TEETH GRINDING               |
| <input type="checkbox"/> VERTIGO            |   |
| <input type="checkbox"/> HAY FEVER          |   |

*Cyina Renee, L.Ac.*

ACUPUNCTURE BEAUTY WELLNESS

# FACIAL ACUPUNCTURE

**3 MAIN CONCERNS:**

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**CURRENT BEAUTY ROUTINE: PLEASE INCLUDE BRAND NAME**

CLEANSER \_\_\_\_\_ TONER \_\_\_\_\_ MOISTURIZER \_\_\_\_\_ MASK \_\_\_\_\_  
 DO YOU USE SUNSCREEN?  YES  NO DO YOU TAKE ASPIRIN OR BLOOD THINNERS? YES \_\_\_ NO \_\_\_

HAVE YOU HAD FACELIFT SURGERY?  YES  NO  FULL  PARTIAL  
 IF SO: WHEN \_\_\_\_\_ WHERE \_\_\_\_\_ SATISFIED?  YES  NO  
 PLEASE ELABORATE \_\_\_\_\_

FACIAL TREATMENTS: TYPE \_\_\_\_\_ HOW OFTEN? \_\_\_\_\_

- |  |  |
|--|--|
| <input type="checkbox"/> MICRODERMABRASION       | <input type="checkbox"/> RETIN-A             |
| <input type="checkbox"/> CHEMICAL PEELS          | <input type="checkbox"/> BOTOX               |
| <input type="checkbox"/> PHOTOLIGHT REJUVENATION | <input type="checkbox"/> COLLAGEN INJECTIONS |
| <input type="checkbox"/> FILLER (TYPE: _____)    | <input type="checkbox"/> OTHER _____         |

**SKIN**

- |                                    |                                  |                                  |                                    |
|------------------------------------|----------------------------------|----------------------------------|------------------------------------|
| <input type="checkbox"/> WRINKLES  | <input type="checkbox"/> DRYNESS | <input type="checkbox"/> HERPES  | <input type="checkbox"/> DULLNESS  |
| <input type="checkbox"/> BLEMISHES | <input type="checkbox"/> OILY    | <input type="checkbox"/> RASHES  | <input type="checkbox"/> ECZEMA    |
| <input type="checkbox"/> ACNE      | <input type="checkbox"/> ECZEMA  | <input type="checkbox"/> SAGGING | <input type="checkbox"/> PSORIASIS |

**DISCOLORATIONS:**  AGE SPOTS  SALLOW (YELLOW) COMPLEXION  ROSACEA (REDNESS)

**EYES**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> DARK EYE CIRCLES | <input type="checkbox"/> DRY SKIN AROUND EYES | <input type="checkbox"/> PUFFY AND SWOLLEN |
| <input type="checkbox"/> WRINKLES         | <input type="checkbox"/> STYES                | <input type="checkbox"/> EYE BAGS          |
|   |   | <input type="checkbox"/> PUFFY UPPER LIDS  |

**NECK**

**LIPS**

- |                                      |  |                                     |                                     |
|--------------------------------------|--|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> CREPEY SKIN | <input type="checkbox"/> SAGGING JOWLS | <input type="checkbox"/> FINE LINES | <input type="checkbox"/> COLD SORES |
| <input type="checkbox"/> WRINKLES    | <input type="checkbox"/> TURKEY WATTLE | <input type="checkbox"/> CRACKING   | <input type="checkbox"/> HERPES     |

**HAIR**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> THIN HAIR           | HAIR FOLLICLE TREATMENTS?                                | <input type="checkbox"/> EXCESS FACIAL HAIR                                       |
| <input type="checkbox"/> ALOPECIA (BALDNESS) | <input type="checkbox"/> YES <input type="checkbox"/> NO | ELECTROLYSIS TREATMENTS: <input type="checkbox"/> YES <input type="checkbox"/> NO |
|  | IF SO, WHEN? _____                                       | IF SO, WHEN? _____  |

*I understand that LED light therapy will be used as part of my treatment.*

*Certain prescription drugs such as tretinoin, antibiotics, and essential oils such as bergamot and citrus can cause photo-sensitivity. Skin conditions such as known skin cancers, seizure disorders and migraines are a concern for LED light therapy. If you have any of these conditions, please list:*

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

HOW WOULD YOU DESCRIBE THE CONDITION OF YOUR SKIN?

DO YOU HAVE ANY ALLERGIES OR SKIN SENSITIVITIES? PLEASE LIST:

WHAT DO YOU LOVE ABOUT YOUR FACE?

WHAT AREAS OF YOUR FACE ARE YOU MOST CONCERNED / SELF-CONSCIOUS ABOUT ...

AND/OR

WHICH FACIAL / SKIN CHARACTERISTICS WOULD YOU LIKE TO SEE ENHANCED AND HOW?

FOREHEAD

---

EYES

---

CHEEKS

---

CHIN

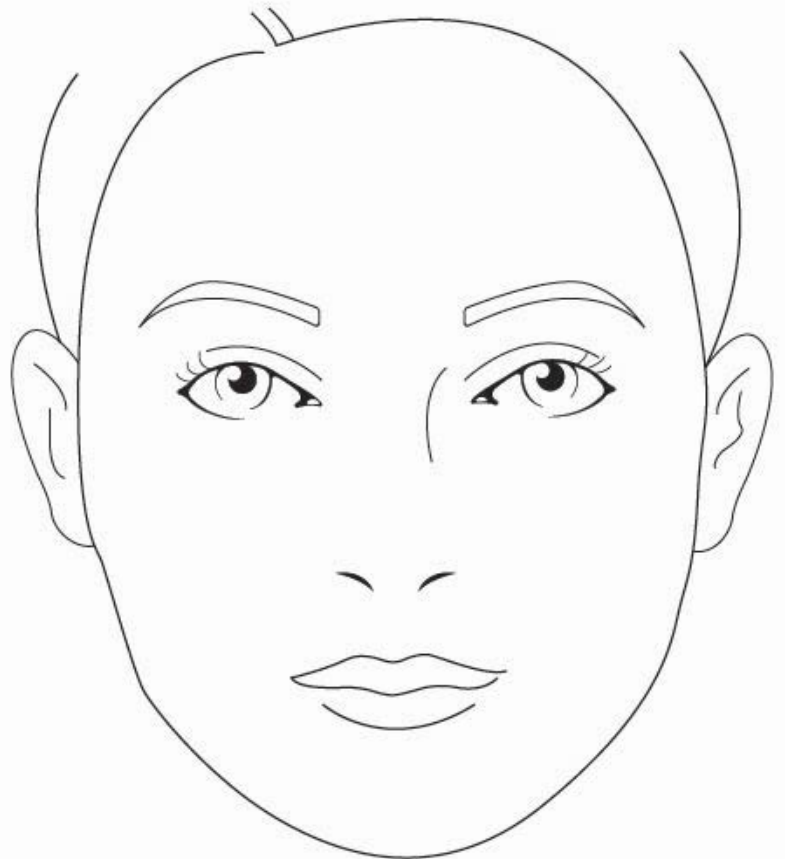
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JAWLINE

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NECK

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# INFORMED CONSENT FOR FACIAL ACUPUNCTURE TREATMENT

**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.

I understand that my treatment may be modified to address: 1) Changes in my condition; 2) changes in my desired results; or 3) changes in the professional standards of acupuncture care. I understand, and agree to adjustments in my treatment as needed to optimally address my well-being, my objectives, and to take advantage of the full range of care options for me.

**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, including micro-current facial treatment.

**POTENTIAL 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. However, I understand that as with all acupuncture care, facial acupuncture treatment involves a gradual, healthful process that is customized for each individual, and that results may vary.

**ALTERNATIVE TREATMENT** - I understand that other alternatives exist for cosmetic care, including, but not limited to, surgery, such as a surgical facelift, chemical face peels, or liposuction. I realize that there are also risks and potential complications associated with these alternative forms of treatment.

**RISKS OF AN ACUPUNCTURE FACIAL TREATMENT** - 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 AND BRUISING** – As with acupuncture in general, some minor bleeding may occur. This is normal and usually will not leave a bruise. Occasionally, a bruise or a hematoma may appear. With bruising, it is important that you wear sunscreen when going outside. Topical and internal remedies will be discussed to address bruising. If swelling persists, I understand, I should call my provider immediately.
- **INFECTION** – Infection at the probe site is very rare after treatment because the probe does not break the skin. If you suspect infection at the probe site (i.e. redness, swelling or warm to the touch), please call me. Additional treatment or referral to your M.D. may be necessary.
- **DAMAGE TO DEEPER STRUCTURES** - Deeper structures such as blood vessels, nerves, 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** – All facial structures are naturally asymmetrical. Results may vary from side to side due to the natural asymmetry, previous injuries on one side of the body, or severity of symptoms from one side or the other.
- **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 a facial acupuncture treatment. You may be disappointed with the results. I understand that I am not having a surgical procedure. The alternatives, risks, and comparisons of surgical procedures versus facial acupuncture treatments have been discussed with me and outlined in this document. Should I have any further questions, I will discuss them with my provider before treatment begins.
- **ALLERGIC REACTIONS** – In rare cases, local allergies to topical preparations have been reported. Allergic reactions may require additional treatment or discontinuation of treatment.

- **DELAYED HEALING** – Delayed healing is a rare complication. Smoking and certain health conditions such as diabetes and chronic fatigue syndrome, to name a few, may delay the healing response of any of the aforementioned risks.
- **LONG-TERM EFFECTS** – Following facial acupuncture treatments, changes in facial appearance may occur as the result of the normal process of aging, weight loss or gain, sun exposure, stress, illness, or other circumstances not related to such treatment. It has been explained that following lifestyle and dietary instructions may enhance the longevity of the results, while non-compliance will adversely affect the longevity of the results from facial acupuncture treatments. Additional, future treatments may be necessary to maintain the results.
- **UNFORESEEABLE IMPACTS** – There are many variable conditions, in addition to the risks and potential complications enumerated, that may influence the long-term result from facial acupuncture treatments. While the complications cited are the ones particularly associated with facial acupuncture treatments, this is not an exact science, and other less common complications may arise. Should these or other complications occur, other treatments might be necessary.

**UNFORESEEN CONDITIONS** – I understand that there are several styles or methods of facial, cosmetic, or rejuvenation acupuncture and have been informed that during the course of facial acupuncture treatments, unforeseen conditions may necessitate different procedures than those listed above.

**HEALTH INSURANCE/FINANCIAL RESPONSIBILITY** – I understand that most health insurance does not cover the cost of the facial acupuncture treatments or complications resulting from such treatments. Please contact your insurance if you have any questions about coverage. Depending on whether any or all of the cost of facial acupuncture treatments is covered by an insurance plan, I will be responsible for charges not so 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.

**AGREEMENT AND CONTINUOUS EFFECT:** I have read, or have had read to me, the above consent. It has been explained to me in a way that I understand: a) The risks involved with facial acupuncture treatments; b) That I have alternatives available to me for cosmetic improvements; and c) What protocols will be used in connection with treatment. I have also had an opportunity to ask questions regarding facial acupuncture treatment, and am satisfied that all my questions have been answered. I acknowledge that no guarantee has been given to me by anyone as to the results that may be obtained. I authorize the release of medical information, when required. Finally, by signing below I acknowledge that I have been fully informed about, and agree to, facial acupuncture treatments. 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.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

---

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

---

**Date**

*Jina Rense, L.Ac.*

---

**Practitioner**

---

**Date**



*Gina Renee, L.Ac.*

ACUPUNCTURE BEAUTY WELLNESS

**SESSION RESCHEDULE/ CANCELLATION / LATE POLICY:**

*Please notify me **at least 2 business days or 48 business hours in advance** if you cannot keep your appointment.*

*You can reach me by phone or text at **831-220-5689***

***All appointments cancelled or rescheduled with less than 48 hours advance notice will be charged 50% of the scheduled appointment fee.***

***In the event of a missed appointment without any notification of cancellation or rescheduling (“no-call, no-show”), you will be charged the full cost of the scheduled appointment fee.*** This includes appointments that are made as part of a package. If you do not call and do not show for a scheduled appointment as part of a package, you will forfeit that session.

**Late appointments are considered cancelled and forfeited 20 minutes past the scheduled appointment time without advance notice, and you will be billed for the full cost of the session.**

*Please contact me at 831-220-5689 if you are running late.*

Thank you for your courtesy and understanding.

*Gina Renee L.Ac.*