AcuZen Cosmetic Acupuncture Informed consent

Informed Consent
Cosmetic Acupuncture involves the insertion of Acupuncture needles into particular points on the body, as well as the use of Microneedling, and Nanoneedling for collagen induction therapy. Microneedling treatment allows for controlled induction of serums and hyaluronic acid into the skin's self-repair process. By creating micro injuries in the skin, these injuries stimulate new collagen production, while not posing the risk of permanent scarring. The result is smoother, firmer and younger looking skin. The skin needling treatments are performed in a safe and precise manner with a sterile, single use needle head.

The purpose of Cosmetic Acupuncture is to create a younger and more vibrant appearance. This may include enhanced skin tone, improved luster of complexion, decreased puffiness around the eyes, elimination or reduction of fine wrinkles, improved muscle tone, firming of sagging skin, and a lessening of the visible signs of aging. It can significantly reduce acne and scarring, as well as help with hair thinning.

Result Guarantees
While Cosmetic Acupuncture has been clinically shown to work; everyone's body, skin, and repair process works differently. The purpose of Cosmetic Acupuncture is to gradually create a younger and more vibrant appearance. This treatment is not a surgical procedure and cannot be compared to a surgical facelift, nor can we provide guarantees as to the success, or results of treatments.

Contraindications/Possible Side Effects:
I understand that with every procedure, there are some risks to treatment. Even though most patients do not experience complications, I understand that problems may arise for me. This may include the possibility of bruising of the skin and/or slight bleeding, weakness, fainting, and/or the aggravation of symptoms existing prior to acupuncture treatment. There is little to no risk of infection as Acuzen uses only sterile, single- use, disposable needles.

Contraindications: Accutane within 6 months**,** Scleroderma, collagen vascular disease, or cardiac abnormalities, rosacea, blood clotting problems, platelet abnormalities, anticoagulation therapy (i.e.: Warfarin), facial cancer past and present, chemotherapy, steroid therapy, dermatological diseases affecting the face (i.e. Porphyria), diabetes and other chronic conditions, active bacterial or fungal infections, immune-suppression, scars less than 6 months old, and Botox/facial fillers in the past 2-4 weeks.
Treatment is not recommended for patients who are pregnant or nursing.
Precautions: Keloid or raised scarring, eczema, psoriasis, actinic keratosis, and herpes simplex.
Side Effects May Include:

- Skin will be pink or red, may feel warm like mild sunburn, tight and itchy, which usually subside in 12-24 hours
- Sunscreen must be worn.
- Minor flaking or dryness of the skin, with scab formation in rare cases.
- Crusting, discomfort, bruising and swelling may occur, as well as minor pinpoint bleeding.
- It is possible to have a cold sore flare if you have a history of outbreaks.
- Freckles may lighten temporarily or permanently disappear in treated areas.
- Infection is rare but if you see any signs of tender redness or puss notify our office.
- Hyperpigmentation (darkening of the skin) rarely occurs and usually resolves itself after a month.
- Permanent scarring (less than 1%) is extremely rare.
- Nerve Injury to the motor or sensory nerve are very rare with facial Acupuncture treatments.
- Delayed healing is a rare complication that may be exacerbated by smoking and certain health conditions such as diabetes.

Bio - Light Therapy
I consent to Bio-Light Therapy Treatments. There are no known side effects. It is a safe and painless technique. There is no risk of burning. Caution should be observed in some cases comprising of eyes vulnerable to photo toxicity, and photosensitive skin.

After Care
Sunscreen must be worn. No facial soap should be used within the first 24 hours after treatment. Warm water may be used to wash the face. Allow 2-3 weeks post treatment to begin seeing results. 4-6 treatments are necessary for overall results. Wait 1 month to repeat Microneedling. Nanoneedling may be used weekly.

Privacy Policy
I understand that Acuzen clinician and administrative staff may review my patient records and lab reports. However, in accordance with HIPAA (Health Insurance Portability and Accountability Act), all my records will be kept confidential and will not be released without my written consent.

Name_____Date_____

Street_____City_____State/Zip_____

Home Phone_____Cell Phone_____E-Mail_____

Age_____Date of Birth_____Male/Female_____Height_____Weight_____

Treatment 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 including Microneedling and Nanoneedling, and have had an opportunity to ask questions. I intend this consent to cover the entire course of treatment for my present condition and forany future condition(s) for which I seek treatment.

I have been informed about the treatment, procedure, indications, expected results and possible side effects.
Although the beneficial results are usually dramatic, I have been informed that the practice of medicine is not an exact science, and that no guarantees can be or have been made concerning the expected results in my case.
I agree to hold harmless and release from any liability Acuzen or any of its officers, directors and / or employees for any condition or result, known or unknown that may arise as a result of any treatment that I receive.

Acupuncturist Name: Dr. Deborah Rothman

Patient Signature: _____

Patient Name (Please Print):_____Date: _____

Office Policy: 24-hour cancellation is required to respect other patients who may be in need of an appointment, as well as the practitioner's time.

** Please note that appointment cancellations require 24-hour notice.

** No shows will be subject to a full office fee. (Initial) _____

Bounced checks will be charged a $35 fee, and checks will no longer be accepted.

I have read and understood the office policies.

Patient Signature: _____

Patient Name (Please Print):_____Date: _____

Photographic Consent: The purpose of before and after photos is to document the progress of the treatments. Such documentation will help you seechanges that could be overlooked. They can also be helpful tools for teaching and demonstrating to prospective patients the potential results

_____I consent to have my pictures taken for comparison purposes.

_____I consent to have my pictures used in your advertising/website materials. I understand that my name will not be disclosed without written permission.

Patient Signature: _____

Patient Name (Please Print):_____Date: _____