Ashland Family Acupuncture

NEW PATIENT MICRONEEDLING

Please complete this document as thoroughly as possible. Some of the questions may seem unrelated to your condition, but they may play a role in diagnosis and treatment. ***All information is strictly confidential***.

PATIENT INFORMATION

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Cell Phone _____ Other Phone_____

Email _____

Date of Birth _____ Age _____ Marital Status _____

Occupation _____ Employer _____

Emergency Contact _____ Phone _____

Name of Primary Physician_____

How did you hear about us? _____ Referred by_____

CONDITIONS

What are your primary facial concerns? _____

_____

Do you have hair balding concerns? If so, explain: _____

PAST FACIAL TREATMENTS

- ☐ facelift surgery; if so, dates: _____
- ☐ acupuncture facials
- ☐ microneedling; if so, dates: _____
- ☐ microdermabrasion; if so, dates:_____
- ☐ chemical peels; if so, dates:_____
- ☐ light rejuvenation
- ☐ laser procedures; if so, dates:_____
- ☐ Renova, if so, dates: _____
- ☐ Retin-A, if so, dates: _____
- ☐ Botox, if so, dates: _____
- ☐ collagen injections; if so, dates:_____
- ☐ microblading; if so, dates:_____
- ☐ other; if so, dates:_____

FACE ROUTINE

- ☐ cleanser
- ☐ toner
- ☐ moisturizer
- ☐ masks
- ☐ sunscreen daily
- ☐ exfoliator

FACE SKIN
- ☐ wrinkles
  - ☐ forehead
  - ☐ lips
  - ☐ nasolabial
  - ☐ eyes (crow's feet)
- ☐ sun damage
- ☐ hyperpigmentation
- ☐ blemishes
- ☐ acne
- ☐ acne scars
- ☐ rosacea
- ☐ dryness
- ☐ oily
- ☐ eczema
- ☐ large pores
- ☐ rashes
- ☐ sagging
- ☐ age spots
- ☐ broken capillaries
- ☐ yellow complexion
- ☐ dull complexion

EYES
- ☐ dark circles
- ☐ wrinkles
- ☐ dry skin around eyes
- ☐ allergies, watery
- ☐ styes
- ☐ puffy & swollen
- ☐ eye bags
- ☐ puffy upper lids

NECK
- ☐ crepe skin
- ☐ wrinkles
- ☐ sagging jowls
- ☐ turkey wattle
- ☐ double chin

LIPS
- ☐ fine lines
- ☐ cracking
- ☐ cold sores

HAIR
- ☐ thinning
- ☐ baldness
- ☐ dry scalp

PERSONAL HEALTH

Are you taking coumadin or warfarin? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No ☐ Maybe

Do you have skin sensitivities or allergies? ☐ Yes ☐ No ☐ Maybe. If so, to what?

_____

Do you have:
Active contagious diseases (shingles, cold sores, etc.) ☐ Yes ☐ No
Open wounds, active acne, and warts ☐ Yes ☐ No
Coagulant or blood thinning therapy ☐ Yes ☐ No
Cancer patients in treatment ☐ Yes ☐ No
Accutane within 3 months ☐ Yes ☐ No
Keloidal fibroma ☐ Yes ☐ No
Discoid Lupus ☐ Yes ☐ No

Do you prefer to have numbing cream applied to your face? ☐ Yes ☐ No
If yes, this service requires an extra hour of application time prior to your treatment. Please notify Nicole prior to your appointment if you choose to have numbing cream. There is no extra charge for this service.

BEFORE TREATMENT

- *Please wash your face.*
- *Please wear loose-fitting, comfortable clothing that is convenient for accessing areas such as the neck and upper chest during treatments.*
- *Eat a light meal prior to your appointment.*

Ashland Family Acupuncture

OFFICE & FINANCIAL POLICIES

Please do not hesitate to ask any questions you might have regarding your visit, your billing, or our policies.

PAYMENT OF SERVICES

- Payments and co-pays are due at the time of service unless arrangements are made in advance.
- Payment can be made with Venmo, cash, check, or credit card. Please see our website for the fees for microneedling: ashlandfamilyacupuncture.com/microneedling
- Please note that there will be a $25 charge for checks returned due to insufficient funds.
- If you foresee any financial challenges, please address them prior to your appointment.

INSURANCE COVERAGE

- Microneedling & Cosmetic Facial Acupuncture are not covered by insurance.

RELEASE OF MEDICAL INFORMATION

- If your insurance is being billed for treatment for conditions other than cosmetic, your insurance company may require medical reports to document our treatment and progress. Signing below authorizes the release of medical information necessary to process your claim.

APPOINTMENT CHANGES AND CANCELLATIONS

- As a courtesy to our office and other patients, we ask that you please notify the office at least 24 hours in advance if you need to cancel or reschedule your appointment.
- Please note that there will be a charge of $100 for all missed appointments and for all appointments canceled or changed without 24 hours notice for all non-emergency situations.

FINANCIAL AGREEMENT

I am receiving or about to receive health care services in this office. I understand that I am responsible for the full payment of all non-insurance related fees at the time services are rendered. If I choose to use my insurance, I understand that I will be responsible for all "non-covered" services, co-insurance, and co-pays associated with my office visit. In addition, I authorize insurance payment of medical benefits to Ashland Family Acupuncture, LLC, Nicole Peterson, LAc.

By signing below, I agree to comply with the office policies stated above which I have read and understand. I also authorize the use of this signature on all insurance submissions.

Name_____

Signature_____ Date_____

Ashland Family Acupuncture

INFORMED CONSENT FOR MICRONEEDLING

This is an informed consent document that has been prepared to help inform you concerning microneedling treatments. It is important that you read this information carefully and completely.

Microneedling, also called collagen induction therapy, is a minimally invasive technique that uses thin needles, typically 12-16 micro tips, to create microchannels in the skin. The “wounds” created help stimulate the skin’s own healing process by producing more collagen and elastin to the areas treated. Cellular turnover is also enhanced and the end result is firmer, smoother skin, more even skin tone, and a reduction of scars, pore size, wrinkles and stretch marks. In addition to the shifts in appearance, the open channels allow for an increase of up to 2000% of products placed on the skin. Microneedling is not analogous to, or a substitute for, a surgical "face lift." Microneedling treatments do not stop the aging process or permanently alter the appearance of the face and neck. Future treatments may be necessary to maintain the results of the microneedling treatment. Photographic documentation will be taken.

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. These alternative treatments can be done by other practitioners. Risks and potential complications are associated with these alternative forms of treatment.

CONTRAINDICATIONS:

- Pregnancy; however, nano needling may be used
- Active contagious diseases (shingles, cold sores, etc.)
- Open wounds, active acne, and warts
- Coagulant or blood thinning therapy
- Cancer patients in treatment
- Accutane within 3 months
- Keloidal fibroma
- Discoid Lupus

RISKS: An individual's choice to undergo microneedling is based upon the comparison of the risk to potential benefit. Although the majority of patients do not experience the following complications, please discuss each of them with your acupuncturist to make sure you understand the risks, potential complications and consequences of microneedling.

- DISCOMFORT OR PAIN: Numbing cream is used, but some discomfort may be experienced during treatment. Pain may include the feeling of burning, stinging and itch.
- BLEEDING: It is possible that you may experience bleeding at the points of insertion. Accumulations of blood under the skin may cause a bruise or hematoma, which will resolve itself over several days. For this reason, we recommend that you avoid scheduling your appointments near important events (e.g. weddings, public talks, outdoor trips, sun exposure, etc).
- ASYMMETRY: The human face is normally asymmetrical. Thus, there can be a variation from one side to the other in the results attained from microneedling.
- BRUISING AND PUFFINESS: There is a possibility of bruising (hematomas), puffiness, blood, tingling, itching, warmth, pain or other symptoms at the site of the needles.
- SCARRING: In rare case, scarring may occur.
- UNSATISFACTORY RESULT: There is the possibility of a poor result from microneedling.
- ALLERGIC REACTIONS: In rare cases, local allergies to topical preparations may occur. Allergic reactions may require additional treatment.
- LONG-TERM: 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 microneedling. Microneedling does not arrest the aging process or produce permanent tightening

of the face and neck. Future microneedling maintenance treatments, or other treatments, may be necessary to maintain the results of microneedling.

- ADDITIONAL CARE NECESSARY: There are many variable conditions in addition to risk and potential complications that may influence the long-term result from microneedling treatments. Even though risks and complications occur infrequently, the risks cited are the ones that are particularly associated with microneedling. Other complications and risks can occur but are even more uncommon. Should complications occur, other treatments may be necessary. Although good results are expected, there is no guarantee or warranty, either expressed or implied, on the results that may be obtained.

SHORT-TERM EFFECTS OF MICRONEEDLING: For 24-36 hours post microneedling, you may experience:

- REDNESS: Your skin may appear red, similar to a mild sunburn, and may be warm to touch.
- DRYNESS: As part of the healing process, skin may have minor flaking or peeling.
- BUMPS or PIMPLES: You may develop small bumps or pimples as the skin is healing.
- HYPERPIGMENTATION*:* As hyperpigmentation and sun spots are treated, they may appear darker and should resolve with additional treatments.

DISCLAIMER: Informed-consent documents are used to communicate information about the proposed procedure along with disclosure of risks 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.

CONSENT

I hereby authorize Nicole Peterson, LAc, MAcOM to perform an acupuncture facial. I have received the INFORMED CONSENT FOR MICRONEEDLING.

I recognize that during the course of a microneedling treatment, unforeseen conditions may necessitate different procedures than those above. I, therefore, authorize the above acupuncturist to exercise her professional judgment. 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.

I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.

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.
D. There are certain contraindications to treatment. I have made my acupuncturist aware of any that apply to me.

I consent to the treatment or procedure and the above listed items. I am satisfied with the explanation.

Name_____

Signature_____ Date_____

Health Information Patient Privacy Act (HIPPA) Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Each time you visit a health care provider, a record of your visit (containing your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatments) is made. This information is often referred to as your health or medical records and serves as a:

• Basis of planning your care and treatment
• Means of communication among the health professionals participating in your care
• Legal document describing the care you received
• Means by which you or a third-party payer can certify that the services billed were actually provided

• A source of Information for public health officials
• An outcomes tool with which we can improve the care we deliver

Understanding Your Health Information Rights
Understanding what is in your record and how your health information is used helps you to ensure its accuracy; make more informed decisions when authorizing disclosure to others; and better understand who, what, when, where, and why others may access your health information. Although your health record is the physical property of the healthcare provider, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information
- Obtain a paper copy of the notice of Information practices upon request
- Inspect and obtain a copy of your health record
- Request to amend your health record
- Obtain an accounting of disclosures of your health information
- Request communications of your health Information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health Information except to the extent that action has already been taken.

We are required to:

- Maintain privacy of your health Information and abide by the terms of this notice
- Provide you with a notice as to our legal duties & privacy practices with respect to your information.
- Notify you if unable to fulfill a requested restriction on disclosure or amendment to record
- Accommodate reasonable requests you may have to communicate health information by alternative means or locations.

We reserve the right to change our practices and to make the changes effective for all protected health information we maintain. If our information practices change, we will notify you the next time you come to our office for treatment. If you have questions and would like additional information, you may contact the office. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer or with the Secretary of Health and Human Services. We will not retaliate if you file a complaint.

I understand that Ashland Family Acupuncture, LLC will use and disclose health information about me in the course of providing care to me. I understand that my health information may include information both created and received by the clinic, may be in the form of written or electronic records or spoken words, and my include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

By signing below, I agree that I have reviewed this privacy practice and agree to these conditions. I will be offered a copy of this form and may request a copy at any time.

Name_____

Signature_____ Date_____