

HUNT VALLEY ACUPUNCTURE AND CHINESE HERBAL MEDICINE

Rabab Al-Amin, M.Ac., L.Ac., Dipl. Ac. (NCCAOM)

410-299-0752 HuntValleyAcu@gmail.com 215 Wickersham Way #1. Cockeysville, MD. 21030

Informed Consent:

Cosmetic Acupuncture involves the insertion of special needles into particular points on the body. There are some risks to treatment, including 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 when all needles are sterile. Hunt Valley Acupuncture And Chinese Herbal Medicine (HVA) uses only one-time use, sterile disposable needles. HVA does not provide Western (allopathic) medical care. Please see your medical doctor for those services and for routine check-ups.

If you are pregnant, have a bleeding disorder, pacemaker, high blood pressure, local infection, or have been prescribed anticoagulant medications like Coumadin, I can still treat you but should be made aware of your condition. By signing below you state that you have informed Rabab Al-Amin of such conditions. Treatments are by appointment only, I always do my best to notify patients of changes in schedules.

Result Guarantees:

While Cosmetic Acupuncture has been clinically shown to work; I want to remind you that everyone's body, skin, and repair process works differently. The purpose of Cosmetic Acupuncture is to create a younger and more vibrant appearance. Please be advised that this treatment is not a surgical procedure and cannot be compared to a surgical facelift. HVA cannot be held liable or bear any responsibility for the actions or results of actions of its Members, nor can we provide guarantees as to the success, or results of treatments delivered by HVA.

Microneedling - Collagen Induction Therapy:

I consent to the treatment of MicroNeedling to be carried out upon myself.

The MicroNeedling treatment allows for controlled induction of growth factor serums, or 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 needle head and are usually completed in 30-60 minutes.

Contraindications:

Absolute 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 Typically Include:

- Skin will be pink or red and may feel warm, like mild sunburn, tight and itchy, which usually subside in 12 to 24 hrs.
- Minor flaking or dryness of the skin, with scab formation in rare cases.
- Crusting, discomfort, bruising and swelling may occur.
- Pinpoint bleeding.

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- 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 immediately.
- Hyperpigmentation (darkening of the skin) rarely occurs and usually resolves itself after a month.
- Permanent scarring (less than 1%) is extremely rare.

Celluma Light Therapy

I consent to Celluma Light Therapy Treatments. There are no side effects known so far. It is a completely safe and painless technique. There is no risk of burning. There are no absolute contraindications to light therapy but caution should be observed in some cases comprising of:

- Eyes vulnerable to photo toxicity
- Tendency towards mania
- Photosensitive skin
- Use of photosensitizing medicine or herbs.

Billing Policy & Acknowledgement of HIPAA Privacy Policy & Consent to Treatment Agreement:

The following sets forth the general billing policy of **Hunt Valley Acupuncture & Chinese Herbal Medicine (HVA) / Rabab Al-Amin, L.Ac., M.Ac.** Please review this information and sign where indicated.

- I understand that payments to **HVA / Rabab Al-Amin, L.Ac., M.Ac.** are due at the time of service.
- I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a \$25 NSF fee. I further understand that to rectify my account, I will be required to pay with cash, a money order, cashier's check, or credit card.
- I understand that I will be billed for any balance due and that I have a financial responsibility to pay these amounts. I understand that in the event there is an outstanding balance on my account that if I have not made payment prior to the second statement being mailed, that the second statement will be marked as "Final Notice" and may be sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with the collection efforts.
- I understand that I will be charged the full fee if my appointment is canceled in less than 24 hours.
- I understand that this is the Notice of Privacy Practices as required by HIPAA from **HVA / Rabab Al-Amin, L.Ac., M.Ac.**, and understand my rights with regard to my personal health information disclosure.

HIPAA Compliance Patient Consent Form:

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement.

The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?

May we leave a message on your answering machine at home or on your cell phone?

May we discuss your medical condition with any member of your family?

If YES, please name the members allowed and their phone numbers: _____

I have not been guaranteed any success concerning the uses and effects of Chinese Herbal Medicine. I understand that I am free to discontinue treatment at any time.

Infectious Disease/Clean Needle Procedures:

I understand that there is infectious disease carried through the air, through physical contact, and through body fluids. I understand that the practitioner follows universally prescribed precautions to guard against the spread of infections. I understand that the practitioner washes her hands, wears gloves and a mask before preparing each herbal formula to guard against contagions by contact.

I understand that my questions about the safety of Chinese Herbs, nutraceuticals and the precautions taken by the practitioner are most welcome, and will be answered as fully as possible.

Chinese herbs: at times, I may not be able to produce lot numbers for raw, granule, tincture, sachets, or salves, balms, and serums.

I have been informed about the treatment, procedure, indications, expected results and possible side effects.

Although the 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 am undergoing treatment of my own free will. I agree that this procedure is being performed for cosmetic reasons. I am also aware of and accept the risk of unforeseen complications that may not have been discussed and which may result from this treatment.

I also agree to hold harmless and release from any liability HVA 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.

Cancellation Policy:

Please give at least 24 hour notice for cancellation.

I understand that I will be charged the full fee for missed appointments, or less than 24 hours cancellations.

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I acknowledge my obligation to follow the instructions closely and visit the office as directed.

I acknowledge that I have read or have had read to me, the terms and conditions of **Hunt Valley Acupuncture and Chinese Herbal Medicine** and fully understand it. Voluntarily signing my name below indicates that prior to signing, all questions regarding this Agreement were answered to my complete satisfaction, that I am satisfied with all the terms and conditions, and I accept and will abide by this agreement.

By signing below, I agree to the above named procedures. I intend this consent to cover the entire course of treatment for my present condition(s).

My signature below confirms that I have read and understand these consent to treatment agreement, billing policies, privacy practices and my financial obligation as pertains to the health care practitioner, **HVA / Rabab Al-Amin, L.Ac., M.Ac.**

Patient's Printed Name: _____

Signature: _____

Date _____ Witness: _____