Dawn Kulak Tubb, M.Ac., L.Ac

The FacePlace Spa
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Consent to Services
I have read and understand this form and acknowledge that the purposes, techniques, limitations, potential risks and benefits of the service to be performed have been explained to me. I have read the Notice of Privacy Practices (below) and understand my rights. Further, I have had the opportunity to ask questions regarding the proposed services, this form, and have received satisfactory explanations. I understand that I am free to discontinue services at any time. I hereby voluntarily consent to acupuncture treatment.

_____ _____
Name Home phone

_____ _____
Address Work phone

_____ _____
City, State, Zip Code Mobile phone

_____ (please indicate preferred contact number)
Email address

_____ _____
Signature of client (or parent or guardian if client is a minor) Date

Services to be Provided
I understand that my treatments may include the insertion of sterile needles, bodywork, gua sha (rubbing of the skin with a smooth object), cupping (the application of glass cups with vacuum to the skin) and/or the application of heat to the skin. I understand that i may refuse any of these techniques.

Risks/Possible Side Effects
I understand that acupuncture may result in certain side effects, including local bruising, slight bleeding, fainting, temporary pain and discomfort, and temporary aggravation of symptoms existing prior to treatment.

No Guarantees
I understand that acupuncture serves individuals with a wide range of complaints including both acute and chronic healthcare issues. I acknowledge that I have not received any guarantees or promises as to the results or success that will be obtained from the services provided.

Client Responsibilities
I understand that it is my responsibility as a client to inform my acupuncturist of all aspects of my health and that, as service progresses, to inform my acupuncturist of changes that occur. I will inform my acupuncturist if I am pregnant and/or suspect pregnancy at any time. If I experience any pain, discomfort or possible adverse side effects, it is my responsibility to immediately notify my acupuncturist.

Medical Treatment
I recognize that an acupuncturist is not a substitute for a medical doctor and will not suggest that I discontinue Under a physician's care, I should continue as long as my physician deems necessary. It is my responsibility to consult with my physician before altering any prescribed medications or treatments. i understand also that if there is an emergency, or a worsening of my health condition, or if a new ailment or condition arises, that I should consult a licensed physician.

Fees and Charges
I have been informed of the fees for service, and I understand that payment is due when the series are provided. If I do not cancel and appointment by phone at least 24 hours in advance, then I am liable for the full amount of the missed appointment.

Notice of Privacy Practices
Health Insurance Portability and Accountability Act (HIPPA) requires that healthcare professionals give their clients a Notice of Privacy Practices and that clients sign in acknowledgement that they received the notice.

- Information you, as my client, share is kept confidential and not shared with anyone unless you sign a separate consent form for the release of information. You have the right to request restrictions and you have the right to review or obtain copy of your health record from me.
- You will be contacted when necessary using the phone number and address you have provided unless you specifically request otherwise.

If you believe your privacy rights have been violated, you have the right to file a complaint with the U.S. Secretary of Health and Human Services (Office of Civil Rights: 1-800-368-1019) with no fear of retaliation