FACIAL ACUPUNCTURE CONSENT FORM

Patient Name: _____
Date of Birth: _____
Date: _____

Please tick to confirm:

☐ I consent to receive facial acupuncture treatment.

☐ I understand that results vary and cannot be guaranteed.

☐ I understand that possible temporary side effects may include **bruising, redness, red marks, pinpoint bleeding, mild swelling, tenderness, skin sensitivity, headache, dizziness, light-headedness, tiredness, nausea and, rarely, infection or other unexpected reactions**.

☐ I understand that bruising may occasionally be noticeable and can take several days or longer to settle.

Botox, Fillers & Injectable Treatments

☐ I have **not had Botox, dermal fillers, skin boosters or other facial injectable treatments within the last 6 weeks**.

OR

☐ I **have had injectable treatment within the last 6 weeks** and have informed my practitioner of **exactly where on my face the treatment was carried out**.

Area(s) treated:

☐ I have informed my practitioner of any relevant medical conditions, medications, pregnancy, skin conditions, bleeding disorders, allergies or recent facial/cosmetic procedures.

☐ I understand that I may ask questions or withdraw my consent at any time before or during treatment.

By signing below, I confirm that the information I have provided is accurate and that I understand and consent to the treatment and associated risks.

Patient Signature: _____

Practitioner Signature: _____

Date: _____