Andrea M. Schilling,MAOM, Lac., L.M.T.

Informed Consent- Acupuncture Facial Rejuvination

I, ___________________________, freely choose to undergo facial acupuncture treatments, knowing that there are no guaranteed results.

I also understand that there could be bruises (hematoma) puffiness, redness, blood, pain or other symptoms at the site of the needles on the face or in the body during or after the treatment.

I completely understand all these ramifications and freely agee to undergo these treatments.

Patient___________________________________Date___________________________

Practitioner____________________________________Date____________________
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