Reset Medical Solutions
Brenna K Galves Dipl. OM, L.A.c, MSTOM
2038 Vermont Dr Unit 207 Fort Collins, Co 80525
info@resetmedicalsolutions.com

Education, Certification and Experience:

Brenna K Galves earned her Master of Science in Traditional Oriental Medicine(MSTOM) degree from Pacific College of Oriental Medicine in San Diego, California on December 15th, 2017. This four-year program consists of 3,300 hours of education including hours treating patients at the schools clinic which involved herbal practice/consultations and working alongside licensed acupuncturists, medical students, and medical doctors. She was certified as a Diplomate in Oriental Medicine by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in February of 2018. She is certified with the Council of Colleges of Acupuncture and Oriental Medicine in Clean Needle Techniques, and is a Reiki practitioner of Usui tradition. Brenna is also trained and experienced in the recommendation and application of adjunctive therapies to acupuncture such as moxibustion, Tui na, acupressure, cupping, auriculotherapy, and dietary and lifestyle recommendations. She is also trained and certified in Facial Rejuvenation Acupuncture, and is a licensed Acupuncturist in the state of Colorado. None of these licenses, certificates or registrations has ever been suspended or revoked.

Clinic Fee Schedule (payment is due at time of service):

Initial Consultation and Treatment (90 minutes) $165.00 + the cost of herbs
Return Acupuncture (60 minutes) $120.00 + cost of herbs
Cosmetic Wellness Consultation and Treatment-New and Returning (90 minutes) $165.00
Cosmetic Wellness Facial (non-needle treatment) (60 minutes) $100.00
Acupuncture and Massage Integration (90 minutes) $140.00
New Patient Herb Consultation only (45-60 minutes) $75.00 + cost of herbs
Return Herbal Consultation (30 minutes) $50.00 + cost of herbs
Cupping/guasha ONLY (30 minutes) $55
Reiki Energetic Healing Session (60 minutes) $75.00
TeleMedicine INITIAL Consultation (60-75 minutes) $145 + the cost of herbs and shipping
TeleMedicine RETURN Consultation (30-45 minutes) $55 + the cost of herbs and shipping
REFUNDS: All paid for treatments including discounted cash packages must be used within 90 DAYS of purchase or the cost of remaining treatments will be forfeit.

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Patient's Rights:

• Patients are entitled to receive information about the methods of therapy, techniques used, and the duration of therapy, if known.
• Patients may seek a second opinion from another health care professional and may terminate therapy at any time (see fee schedule, late policies, early termination terms).
• In a professional relationship, sexual intimacy is never appropriate and should be reported immediately to the Director of the Division of Registrations in the Department of Regulatory Agencies.
This clinic complies with all rules and regulations promulgated by the Colorado Department of Public Health, including the proper cleaning and sterilization of needles and the sanitation of the acupuncture office. The practice of acupuncture is regulated by the Colorado Department of Regulatory Agencies. Any complaints should be directed to:

Colorado Department of Regulatory Agencies
Division of Professions and Occupations
1560 Broadway, Denver, CO 80202

Signature of patient: _____ date: _____

Consent Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Materia Medica of Chinese Medicinal Herbs by Brenna Galves, L.A.c., Dipl. OM who is a licensed acupuncturist in the state of Colorado. I understand that acupuncturists practicing in the state of Colorado are not primary care providers.

Acupuncture: I understand that acupuncture means the stimulation of certain points on the surface of the body by the insertion of needles through the skin to modify or prevent pain perception and/or to normalize physiological functions in an attempt to treat disease or dysfunction of the body. I understand that acupuncture treatment may include the use of moxibustion, electro-acupuncture, and/or acupressure. I have been made aware that certain adverse side effects may result which could include, but are not limited to; local bruising, minor bleeding, fainting, temporary pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

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Moxibustion: I understand that moxibustion means the therapeutic application of direct or indirect heat to the skin at certain points on or near the surface of the body. I have been made aware that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Electro-Acupuncture: I understand that electro-acupuncture means the therapeutic use of weak electric currents to stimulate acupuncture points. I have been made aware that certain adverse side effects may result which include, but are not limited to; electric shock, temporary pain or discomfort, and the possible temporary aggravation of symptoms existing prior to acupuncture treatment. I understand that I may refuse this therapy.

Acupressure/Massage: I understand that I may be given acupressure or Oriental massage as part of my treatment to modify or prevent pain perception and/or to normalize physiological functions in an attempt to treat disease or dysfunction of the body. I have been made aware that certain adverse side effects may result which could include, but are not limited to; muscle soreness and the possible temporary aggravation of symptoms existing prior to treatment. I understand that I may stop this therapy if this is uncomfortable. Furthermore, I understand that this procedure is for therapeutic purposes only and that in a professional relationship sexual intimacy is never appropriate.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to modify or prevent pain perception and/or to normalize physiological functions in an attempt to treat disease or dysfunction of the body. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I have been made aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to; changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems that I associate with these substances, I should suspend taking them and call the acupuncture clinic as soon as possible.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I give my permission and consent to treatment by the above named acupuncturist.

_____ _____

Patient signature Date

_____ _____

Printed Name Date of Birth

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Patient Health History

Full Legal Name:_____Date:_____

StreetAddress_____

City: _____ State:_____ Zip:_____

Phone:_____ DOB:_____ Age: _____ Gender: M/ F

Marital Status:_____ Occupation:_____

Hours per week:____ Employer:_____

Email address:_____

Emergency Contact:_____Phone:_____Relationship:_____

Referred by(So I can thank them!) or how you heard of me_____

Chief Complaint/Reason for visit:

_____

When did this condition begin?

_____

Describe symptoms you are currently having

_____

_____

_____

Please state diagnosis (if known)

_____

What diagnostic tests (if any) have been done?

_____

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What treatment(s) have you already received for this condition?

_____

Has any treatment helped (if yes, please explain)?

_____

Do you have any other health concerns? (please list in order of importance)

1)

_____

2)

_____

3)

_____

4)

_____

5)

_____

Are you allergic or hypersensitive to any foods, drugs, or environmental allergens?

YES/ NO

If yes, please describe:

_____

Do you have any infectious/contagious disease? YES/ NO

If yes, please explain:

_____

Are you currently suffering from any chronic illness? YES/ NO

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If yes, please explains:

_____

Major Medical

Please list any hospitalizations, surgeries, significant illnesses, or traumas you have experienced in your life:

1) _____ Date: _____

2) _____ Date: _____

3) _____ Date: _____

4) _____ Date: _____

5) _____ Date: _____

Current Medications

Please list all prescription medication (including hormones or birth control pills), over-the-counter medications, vitamins, herbs, or supplements you are taking and your reason for taking them (you may attach your own copy if that is easier):

1) _____ Dosage: _____ Reason: _____

2) _____ Dosage: _____ Reason: _____

3) _____ Dosage: _____ Reason: _____

4) _____ Dosage: _____ Reason: _____

5) _____ Dosage: _____ Reason: _____

6) _____ Dosage: _____ Reason: _____

Are you vegetarian or vegan? YES/ NO

Are you on any specific diet? YES/ NO If yes, please describe: _____

Do you smoke cigarettes? YES/ NO If yes, how many per day? _____

Do you drink alcohol? YES/ NO If yes, how many drinks per week? _____

Are you pregnant or have any reason to believe you may be pregnant? YES/ NO

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Overall, the state of your health is: Excellent Good Average Fair Poor

How much are you willing to change your life overall to reach your healthcare goals?

None Some Moderate Complete

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1. **In your opinion, what has happened to your health?**

2. **When was the last time in your life that you felt 100% with your healthcare?**

3. **What are your top 3 healthcare goals in the next year?**