

Reset Medical Solutions

New Patient Paperwork

A. Consent Form

Name: _____ Date of Birth: _____ AGE: _____
Address: _____ City: _____ State: _____
Zip Code: _____ Phone: _____ Email: _____

I, _____, consent to undergo acupuncture therapy performed by a licensed provider at Reset Medical Solutions. I understand that acupuncture involves the insertion of fine needles into specific points on the body to promote healing and alleviate symptoms.

Key Points of Consent:

1. ***Nature of Treatment:*** I understand that acupuncture involves the insertion of sterile, disposable needles into specific points on the body to stimulate energy flow, relieve pain, or address specific health conditions. 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. ***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.
2. ***Procedure Explanation:*** The practitioner has explained the treatment plan, including the number of sessions, duration, and expected benefits or potential risks.

3. **Risks and Benefits:** I understand that while acupuncture is generally safe, potential risks may include bruising, soreness, or slight bleeding at needle insertion sites. Rare complications like infection or nerve damage could occur but are extremely uncommon.
4. **Alternatives and Options:** I have been informed of alternative treatments or therapies available for my condition and have chosen acupuncture after considering these options.
5. **Confidentiality:** I acknowledge that my health information will be kept confidential and will only be shared with other healthcare providers if necessary for my treatment.
6. **Consent for Treatment:** I voluntarily consent to undergo acupuncture treatment and understand that I have the right to withdraw my consent at any time.
7. **Cost and Payment:** I understand the cost of the acupuncture sessions and the payment arrangements. I have been informed about insurance coverage, if applicable.

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

A. Acupuncture and Chinese Medicine

Initial Consultation and Treatment (90 minutes) \$165.00 + the cost of herbs

Nanoneedling/Microneedling-New and Returning (90 minutes) \$165.00

45 Minute Reset- \$70 + the cost of herbs

60 Minute Reset-\$100 + the cost of herbs

75 Minute Reset-\$120 +the cost of herbs

90 Minute Reset- \$150 + the cost of herbs

2 Hour Reset- \$200 + the cost of herbs

Esoteric Acupuncture Consultation and Treatment-\$165.00 + the cost of herbs

Please note that we only offer a package deal to save money on 75 Minute Reset. You must purchase 2 or more 75 Minute Resets to receive a discount on services. Please also note that discounts are not to be combined unless otherwise advised/stated on a case-by-case basis.

B. StemWave (Extracorporeal Shockwave Therapy)

ONLY OFFERED IN LOVELAND

(SEPARATE CONSENT FORM TO BE SIGNED FOR ALL STEMWAVE TREATMENT)

StemWave "Mapping"- \$50.00/AREA

StemWave one-time Follow up- \$150.00/AREA

StemWave "add-on" Reset- \$100/AREA (ONLY ADDED ON TO ACUPUNCTURE TREATMENT)

StemWave pkg of 20- \$1500.00/AREA(MUST BE USED WITHIN 5 MONTHS-BEST VALUE.

StemWave Treatment Plans

1 Treatment Area

Package of 6- \$600
Package of 8- \$777
Package of 10- \$950
Package of 12- \$1,111

2 Treatment Area's

Package of 6- \$1,200.00
Package of 8- \$1,507.00
Package of 10- \$1,750.00
Package of 12- \$1,950.00

3 Treatment Area's

Package of 6- \$1,800.00
Package of 8- \$2,150.00
Package of 10- \$2,575.00
Package of 12- \$2,888.00

Licensed Providers

Brenna Galves L.A.c., Dipl OM
Colorado License: ACU.0002389
NCCAOM: 169015

Megan Perry L.A.c.
Colorado License: ACU.0001982
NCCAOM: 124777

Signature and Date: By signing below, I acknowledge that I have read and understood the information provided above and agree to undergo acupuncture treatment.

Patient's Signature: _____ Date: _____

(Minor under the age of 18 must have parent sign for legal documentation BELOW in addition to signature of minor ABOVE)

Legal Guardian Signature: _____ Date: _____

Please Circle YES or NO:

Do you currently have a pacemaker? Yes No

Have you recently had an organ transplant or blood transfusion? Yes No

B. Patient Health History

Marital Status: _____ Occupation: _____ Hours per
week: _____ Employer: _____
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?

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
If yes, please explain:

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

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

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?