Reset Medical Solutions

Central | (970) 889-0521 | info@resetmedicalsolutions.com

Informed Consent for Acupuncture and Integrative Treatment

I request and consent to acupuncture and related procedures — including Traditional Chinese Medicine (TCM), Chinese herbal medicine, cupping, gua sha, moxibustion, electroacupuncture, and facial/cosmetic acupuncture — performed on myself (or the named patient, if I am the parent/guardian) by Brenna Galves, L.Ac., Dipl. OM, MSTOM and authorized staff of Reset Medical Solutions.

Possible risks include minor bleeding, bruising, or soreness; temporary symptom flare; fainting/dizziness; rare infection; skin irritation from cupping/gua sha; allergic reaction to herbs or topicals; and rare pneumothorax. Results cannot be guaranteed. I have discussed my condition, proposed treatment, alternatives, risks and benefits with the practitioner, and understand I may withdraw consent at any time.

I understand Reset Medical Solutions is self-pay and does not bill insurance directly. An itemized receipt (superbill) is available on request for possible reimbursement submission; reimbursement is not guaranteed. Payment is due at time of service. By signing, I confirm I have read and understood this consent.

Patient / Legal Guardian Signature	Date	Printed Name

Fee Schedule — Effective July 1, 2026

Reset Medical Solutions is self-pay and does not bill insurance. A superbill is available on request. Payment in full is due at time of service.

Acupuncture Services

New Patient Consultation & Treatment (90 min) — required for all new patients	**$180**
45 Minute Reset (returning)	**$80**
60 Minute Reset (returning)	**$110**
75 Minute Reset (returning)	**$120**
90 Minute Reset (returning)	**$165**
2 Hour Reset (returning)	**$220**
Cosmetic Wellness	**$180**

No Refunds: Your Health Is Your Wealth. All fees are final once services are rendered.

Patient / Legal Guardian Signature	Date	Printed Name

Patient Health History

If helpful, please attach any related documents (e.g., recent blood work, a medication/supplement list, or records of extensive hospitalizations or medical history).

Full Name:	Date of Birth:
Phone:	Email:
Address:	Emergency Contact (Name & Phone):
Primary Care Physician:	Referred By:

Chief Complaint

Primary health concern(s):

When did this begin?:	What makes it better / worse?:

Medical History

Current medications & supplements:

Known allergies:

Chronic conditions:	Past surgeries / hospitalizations:

Family medical history:

Lifestyle

Occupation:	Exercise habits:
Sleep (quality / hrs per night):	Stress level (1–10):
Tobacco / alcohol / drug use:	Diet / typical daily intake:

Safety Screening

Please note any that apply to you — this helps us treat you safely.

Pacemaker / implanted electronic device:	Bleeding disorder or blood-thinner use:
Seizure disorder:	Diabetes:
Latex allergy:	Metal allergy:
Active skin infection / open wound at treatment site:	Lymphedema or mastectomy history:
History of fainting during needling or blood draws:	Immunocompromised / on immunosuppressants:
Keloid scarring history:	Recent surgery (site & date):

For Female Patients

Pregnant / trying to conceive / nursing?:	Menstrual cycle notes:

Additional Notes

Anything else the practitioner should know:

I certify the above information is accurate and complete to the best of my knowledge.

Patient / Legal Guardian Signature	Date	Printed Name

HIPAA Authorization for Use or Disclosure of Health Information

Optional — only needed if you'd like Reset Medical Solutions to share records with another provider or party.

Patient Name:	Date of Birth:

Information to be disclosed (e.g., treatment records, superbills, treatment plan):

Disclose To

Name of provider / party:	Relationship / role:

Phone / Fax / Address:

Purpose of disclosure:

- Remains in effect until revoked in writing, or 1 year from date signed, whichever comes first.
- May be revoked at any time in writing, except where action has already been taken in reliance on it.
- Information disclosed may be subject to redisclosure and may lose federal privacy protection.
- Treatment, payment, and enrollment are never conditioned on signing this authorization.
- A copy of this authorization is available upon request.

Patient / Legal Guardian Signature	Date	Printed Name