CastelliniCare
206 Broad Street, Red Bank, NJ 07701 732–219-1900

CONSENT FOR FACIAL ACUPUNCTURE TREATMENT

I hereby authorize **CASTELLINI CARE** and such assistants as may be selected to perform acupuncture treatments. I have received the following information sheet:

INFORMED CONSENT FOR FACIAL REJUVENATION ACUPUNCTURE

(Facial Acupuncture Treatment)

I recognize that during the course of the acupuncture facial, unforeseen conditions may necessitate different procedures than those previously mentioned. I therefore authorize the above acupuncturist and assistants or designees to perform such other procedures that are in the exercise of his or her professional judgment necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my acupuncturist at the time the procedure is begun.

I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.

It has been explained to me in a way that I understand:

- The above treatment or exposure to be undertaken
- There may be alternative procedures or methods of treatment
- There are risks to the procedure or treatment proposed

I CONSENT TO THE TREATMENT AND THE ABOVE LISTED ITEMS. I AM SATISFIED WITH THE EXPLANATION.

Patient's Name (Please print)

Patient's Signature Date