Acupuncture & Herb Center
Marlene Klein, L.Ac.
990 Grove Street
Healdsburg, Ca 95448
(707) 431-2528

Office Policy

Initial visit, complete history, exam and treatment 1 ½ hours to 2 hours	$ 140.00
Subsequent treatment	$ 70.00
***Initial** Facial Rejuvenation Session, 1 ½ - 2hours (includes history &"The Works")*	$ 145.00
Facial Rejuvenation Session, approx. 75 min. "The Works" (includes skin care gel, mud or glycolic mask, renewal cream, facial massage, neck probe rejuvenation & foot rub)	$ 125.00
Facial Rejuvenation Session, approx. 60 min. "Regular" (includes neck probes & foot rub)	$ 95.00

After 10 completed Facials, the 11th Facial is free. If 15 Facials needed and scheduled, 16th free.

Herbal formulas, tinctures, supplements, lab tests are a separate charge at a basic price, unless otherwise stated.

- ***Payment is expected at the time of your visit**, unless other arrangements have been made in advance. Cash, checks, money orders or credit cards are accepted.*

CANCELLATION AND LATE ARRIVAL

*Time is reserved for you. I require a **24-hr.notice of cancellation** unless an absolute emergency arises. Full payment will be charged for any missed appointment or late cancel.*
If I am running late, you will still receive your full scheduled treatment. I tend to be on time, but occasionally will run 10-15 minutes behind. Your patience is always appreciated. If you arrive late for your appointment, you will receive a treatment within the time frame allowed.

REFERRALS

I truly appreciate your referrals of friends, family and people in need. I believe in giving back to my clients, so.... for every person you have referred to me that schedules and keeps at least four appointments, you receive 25% off your next session with me. (This does not apply to facial rejuvenation sessions; there are other promotions for that.)

I warmly welcome you, your family and friends to my practice. It is extremely important for us to communicate with each other and to have our relationship based on trust and honesty. If there is ever a problem, please let me know so we can discuss it and work it out together. This will enable me to provide the best health care possible, thus allowing both of us to achieve the greatest benefits.....
Your good health.

With my signature below, I agree to all of the above terms and conditions.

_____
Please print Full Name

_____ _____
Signature ***Date***

Rev. 12/2011

Informed Consent To Rejuvenation Treatments

I hereby request and consent to the performance of rejuvenation treatments, including application of electrical stimulation, color light therapy, sound waves and skin care products on me (or on the client/patient named below, for whom I am legally responsible) by the health care or esthetic practitioner named below and/or other professionals and their assistants who now or in the future treat me while employed by, working, or associated with the health care or esthetic professional named below.

I have had an opportunity to discuss with the practitioner named below and/or with other office or spa personnel the nature and purpose of rejuvenation services and other procedures. I understand that results are not guaranteed.

I understand and am informed that, in the practice of rejuvenation services, there are some risks with treatment, including, but not limited to, bruising, swelling, skin irritation or discoloration, fainting and/or dizziness, and headaches. I understand that such reactions are unlikely and rare, but possible. Discomfort due to the process of detoxification triggered by the therapeutic current and/or light is also possible. I take responsibility to tell the practitioner about any health concerns I have about receiving treatment, and will specifically will inform the practitioner if I am subject to any epileptic or seizure disorder, for which rejuvenation services are contraindicated.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to receive the above-named procedure. I intend this consent form to cover the entire current course of treatment, and any future courses of treatment I seek.

To be completed by client:

_____
Print Client's Name

_____
Signature of Client

_____
Date Signed

To be completed by client's representative, if necessary e/g/, if client is a minor.

_____
Print Name of Client

_____
Print Name of Client's Representative

_____
Signature of Client's Representative

As: _____
Relationship of Authority of Client's Representative

_____
Date Signed

Name and Address of Practitioner:

_____

_____

_____

_____

Witness To Client's Signature: _____