

5D WELLNESS

Melanie Benninger, MSOM, L.Ac.

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Colorado Mandatory Disclosure Statement

Education and Experience

Melanie Benninger earned her Master of Science in Oriental Medicine degree from the Boulder campus of Southwest Acupuncture College in 2020. This four-year program consists of over 3,000 hours of classroom education and over 800 hours of clinical practice. She was certified as a Diplomate of Oriental Medicine by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in October 2020. This includes certification in Clean Needle Technique and Chinese Herbology. Melanie is also certified as a Diplomate in Acupressure by the Natural Therapies Certification Board. Melanie’s training includes adjunctive therapies such as injection therapy, craniosacral therapy, moxibustion, tui na, cupping, and dietary and lifestyle recommendations. Melanie is a licensed acupuncturist in the state of Colorado and has never had her license suspended or revoked.

Fee Schedule*

5D Energy Alchemy Session: \$80 / 45-minute session

5-Session Package: \$75 / 45-minute session, \$375 total

11-Session Package: \$70 / 45-minute session, \$770 total

Each client is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known. Clients may also seek a second opinion from another healthcare professional or may terminate therapy at any time.

In a professional relationship, sexual intimacy is never appropriate and should be immediately reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

I have read and understand this document:

Patient’s printed name:_____

Patient or guardian signature:_____ Date:_____

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CONSENT TO TREATMENT FORM

By signing below, I do hereby voluntarily consent to be treated with distal telehealth energetic modalities by a licensed acupuncturist in this clinic.

Energy Alchemy: I understand that big energetic shifts may create fatigue or the exacerbation of stuck emotions in order to promote the release and integration of stuck energies. I understand that it is important for me to stay hydrated and support myself with self-care such as meditating, journaling, physical exercise, time in nature, eating nourishing foods, and sleeping in order to promote the healthy release of stuck energies and support the cellular detox that occurs with the release of long-standing emotions.

I understand that all modalities of alchemizing energy are only possible with my consent and intentional thought or intention to release resistance. I understand that I am solely responsible for any energetic shift that occurs because nothing outside of myself is able to influence me without my consent.

I understand that all energetic modalities are non-religious, inclusive of all peoples, and based upon the premise that we are able to change our realities and circumstances through our thoughts and intentions.

I understand that I may refuse treatment by any modality at any time and that I may ask my practitioner for a more detailed explanation of any method used. By my signature below, I indicate I have carefully read and understand all of the above information and give my permission and consent to treatment.

Patient's printed name: _____

Patient signature: _____ Date: _____

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PATIENT INFORMATION

Name: _____ Birth date: _____

Mailing address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email _____ Gender identity: _____

How do you prefer to be contacted? (check one) text _____ phone _____ email _____

When was the last time you visited a medical doctor? _____

Name of emergency contact: _____ Phone: _____

How did you hear about us? _____

CONFIDENTIALITY AND PRIVACY AGREEMENT

We value our relationship and respect your right to privacy. Our office complies with HIPAA rules and procedures regarding confidentiality. We do not share your medical information without your written consent. If you have specific questions about our privacy guidelines, please ask your practitioner.

NON-DISCRIMINATION COMMITMENT

Our practice respects all aspects of people including age, gender, race, ethnicity, religion/no religion, national origin, language, education, marital status, body size, political affiliation/philosophy, sexual orientation, gender identity/expression or variance, physical and mental ability, social-economic status, genetic information and HIV and veteran status.

5D WELLNESS FINANCIAL POLICIES

Our office accepts payment by credit card, debit card, or HAS card on the day services are rendered. We do not accept payment through insurance.

Please note that our clinic has a 24-hour appointment cancellation policy. If you cancel your appointment less than 24 hours in advance, you will receive an invoice for the full cost of services scheduled. Thank you for your consideration.

Printed name: _____

Patient signature: _____ Date: _____

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CONFIDENTIAL PERSONAL HEALTH HISTORY

Name: _____

Please leave any questions blank that do not apply to you.

What is your primary reason for your appointment today?

When did this illness/injury start? _____ Were symptoms gradual or acute? _____

Are symptoms worse at a particular time of day or after a specific activity?

What makes the symptoms better? _____ Worse? _____

Have you received any other treatments or interventions for illness/injury? If so, what type of treatment did you receive, and did you experience relief of your symptoms?

People typically experience the best results with energetic modalities with regular treatments for a period of time that varies according to the severity and duration of the symptoms experienced. What is your best schedule for treatment? (check one)

Biweekly _____ Weekly _____ Bimonthly _____ Monthly _____

How committed are you to feeling relief from you symptoms? (circle one)

Very committed to feeling total relief . . 1 . . 2 . . 3 . . 4 . . 5 . . 6 . . 7 . . 8 . . 9 . . 10 . . Looking for mild symptom relief

Why? _____

Please list all allergies, including medical, environmental, food, etc.

Medications, supplements, and herbs you currently take, with dosages:

Surgeries and hospitalizations, including dates:

Have you been diagnosed with any chronic, long-term, or infectious illnesses (for example, diabetes, autoimmune disorders, hypertension, hepatitis, asthma, etc.)?

Have you been diagnosed as "pre-diabetic" by your physician? _____

Are you currently undergoing a difficult life transition, such as a change in career, a divorce, a move, or caring for an aging parent? _____

Is there anything else you would like us to know about you or discuss today?

Thank you.