5D WELLNESS
Melanie Benninger, MSOM, L.Ac.
melanie@5d-wellness.com / P. (720) 443.2963

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*

New patient private treatment: $120 / 90 min
Return treatment: $80 / 60 min
Injection therapy treatment: $50 / 30 min
New patient herbal consult (no acu): $60 / 45 min
Return herbal consult (no acu): $30 / 20 min

Discount Packages*

6 treatments for $450 (save $70) →
$75 / 60-min treatment + no initial treatment fee
12 treatments for $840 (save $160) →
$70 / 60-min treatment + no initial treatment fee

This clinic complies with the rules and regulations promulgated by the Colorado Department of Health, including the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are utilized.

Each patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known. Patients 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.

The practice of acupuncture is regulated by the Colorado Department of Regulatory Agencies. If you have comments, questions or complaints, contact the office of the Director of Professions and Occupations, Acupuncturist Licensure at 1560 Broadway, Suite 1350, Denver, Colorado 80202, call 303.894.7800 or email dora_acupunctureboard@state.co.us.

I have read and understand this document:

Patient's printed name:_____

Patient or guardian signature:_____ Date:_____

5D WELLNESS
Melanie Benninger, MSOM, L.Ac.
melanie@5d-wellness.com / P. (720) 443.2963

CONSENT TO TREATMENT FORM

By signing below, I do hereby voluntarily consent to be treated with acupuncture, acupressure, craniosacral therapy, cupping, moxibustion, injection therapy, and/or substances from the Chinese Materia Medica by a licensed acupuncturist in this clinic.

Acupuncture: I understand that acupuncture is performed by the insertion of needles through the skin at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment may occur. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although this clinic uses sterile disposable needles and maintains a clean and safe environment.

Chinese Herbs: I understand that substances from the Chinese Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances. If I do choose to take Chinese herbs, I am advised to follow the directions for administration and dosage so that the maximum medicinal benefit will be achieved. I am aware that certain adverse side effect may result, such as changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems associated with these substances, I should suspend taking them immediately.

Injection Therapy: I understand that injection therapy may cause soreness or bruising in the injected muscle or tissue within 48-72 hours of administration. I understand that my symptoms of pain and muscular tension may be initially exacerbated by injection therapy before I feel relief. While infection is a possible risk, this clinic uses sterile disposable needles and all necessary safety precautions to maintain a clean and safe environment.

Moxibustion: I understand that moxibustion can result in burning or scarring.

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment and that bruising, sore muscles, and the possible aggravation of symptoms existing prior to treatment could result.

Cupping: I understand that cupping can result in bruising.

I understand that I may refuse treatment by any of these modalities at any time and that I may ask my practitioner for a more detailed explanation of any of the above methods. 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:_____

5D WELLNESS
Melanie Benninger, MSOM, L.Ac.
melanie@5d-wellness.com / P. (720) 443.2963

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_____

Name of your physician:_____Contact number (if known):_____

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 cash, check, credit or debit card, Venmo, or PayPal 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:_____

5D WELLNESS
Melanie Benninger, MSOM, L.Ac.
melanie@5d-wellness.com / P. (720) 443.2963

CONFIDENTIAL PERSONAL HEALTH HISTORY

Name: _____

What is your primary reason for visiting our office 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 acupuncture and oriental medicine 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.