

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*

New patient herbal consult: \$75 / 60 min

Return herbal consult: \$40 / 30 min

This clinic complies with the rules and regulations promulgated by the Colorado Department of Health, including the proper sanitation of the acupuncture and apothecary offices.

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 profession 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: _____

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CONSENT TO TREATMENT FORM

By signing below, I do hereby voluntarily consent to be treated with substances from the Chinese Materia Medica by a licensed acupuncturist in this clinic.

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 effects 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.

I understand that Chinese herbal medicine is an internal and topical medicinal modality that seeks to mitigate the symptoms of illness and address the underlying root causes of energetic disharmony and organ dysfunction. Custom herbal prescriptions that address the underlying causes of illness and their manifestations may change throughout the course of treatment as the patient's condition improves. The end goal of Chinese herbal treatment is to restore the body's organic functionality and ultimately remove the need for any herbal substance use. The course of herbal treatment varies from patient to patient and depends upon the duration and severity of the condition.

I understand that Melanie Benninger is not licensed to prescribe, reduce the dosage, or recommend the cessation of Western pharmaceutical drugs. Please consult your primary care physical or licensed MD specialist for guidance on how to properly reduce the dosage or cease taking any pharmaceutical medication if that is your intention.

I understand that I may refuse treatment by Chinese herbal substances at any time and that I may ask my practitioner for a more detailed explanation 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: _____

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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? _____

Do you prefer to pick up your herbs in person or have them shipped to you? Pick up _____ Shipped _____

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: _____

What is your primary reason for your appointment?

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? _____

What makes the symptoms 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?

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.