Colorado Mandatory Disclosure and Consent Form for Acupuncture

Acupuncture, acupressure, moxabustion, cupping, bleeding, allergy elimination, electro-acupuncture, nutritional or herbal counseling are considered experimental procedures and are not considered to be a substitute for Western Medicine. Therapies and advice offered shall not be construed by the client to be a diagnosis or treatment of any disease or injury.

I understand that complications may result from the acupuncture treatment. Among these possibilities are areas of anesthesia, fainting, weakness, nausea, bruising, infection, pain, discomfort, pnuemothorax, burning or scarring, hemophilia, and aggravation of present symptoms. Being hungry, tired, or stressed infrequently cause the body to be more sensitive to treatment. Please tell your provider if you have conditions that may inhibit blood clotting, such as hemophilia, or Coumadin use. Please use caution walking in bare feet in the treatment room. I, the patient, further understand and agree to hold harmless, indemnify and protect against court action the individual acupuncturist as well as the management and owners of the clinic, in the event of accidental injury on these premises.

We gladly accept auto claims, workman's comp, and insurance payment. Insurance coverage depends on your plan. Please call your insurance provider ahead of time to determine what your benefits are.

Colorado law requires all acupuncturists provide the following information to clients on their first visit:

<u>Education, Experience, Degrees, Certificate, Credentials, Licenses, Regulations:</u>
Joanne Trujillo, L.Ac, MSOM has been issued by the state of Colorado, which requires that she graduate from an approved institution (a four year program), and pass the National Board Exam (NCCOAM) for acupuncture and Oriental Medicine. Joanne has never had any registration, license, or certification revoked by any local, state, or national agency, revoked or suspended.

Cash Fee Schedule
Initial Acupuncture Exam/Treatment in Office……. ……. $140
Follow up Office Visit……. $95
Pediatric Initial Session ……...$90
Pediatric Follow Up……..$65
Package Options available at a discounted rate……...Please ask the provider

*All fees are due at time of service, unless other arrangements have been made with the provider.
*If insurance benefits are being applied, I, the patient, understand that I am responsible for payment of any balances that may accrue due to non-payment by the insurance company.

This provider/office complies with all rules and regulations set forth by the Colorado Department of Health related to proper cleaning and sterilization of needles used in the practice of acupuncture and the sanitation of acupuncture offices. This provider uses only single-use disposable needles, and disposes of them in the manner consistent with OSHA and Colorado State regulation. Each patient is entitled to information regarding the methods of therapy, techniques, and duration of treatment, if known.

The practice of acupuncture is regulated by the Department of Regulatory Agencies. For questions please contact the Director of Registrations Acupuncture Licensure at 1560 Broadway, Suite 1350 in Denver, CO 80202. The phone number is 303.894.7800.

Release of Information
All information provided herein is true and correct. I hereby consent to treatment. I give permission to my provider and staff to release information, verbal and written, contained in my medical record and other related information to related health care providers, assignees and/or beneficiaries and other related persons. *The HIPPA privacy notice was made available to me and I have read and understand this release.*

Appointment Cancellation & Payment Due Policy
I understand that 24 hours notice is required when canceling an appointment. I also understand that 100% of the service will be charged if I do not cancel 24 hours prior to the appointment.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ Date: _____

Printed Name: _____Date of Birth: _____

Joanne Trujillo, Licensed Acupuncturist, MSOM