Colorado Mandatory Disclosure Statement & Informed Consent
Boulder Body Balance Acupuncture & Heavenly Massage
3004 Folsom Street., Boulder, CO 80304
Phone: (720) 509-9588
www.boulderbbacupuncture.com
heavenlymac.com

Name: _____Date: _____

Phone Numbers: (home) _____Work/Cell_____

Email address: _____Birth date: _____Age: _____

Address/City/State/Zip: _____

Gender: M/F Number of children: _____Emergency Contact & Relationship: _____

Telephone: _____How did you hear about this clinic: _____

Boulder Body Balance Acupuncture and Heavenly Massage practitioners are all licensed and board-certified in the state of Colorado. 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 office. Only single-use, disposable, factory-sterilized needles are utilized.

INSURANCE POLICY: If your insurance company covers acupuncture or massage we will verify and bill for you. An Office Visit fee of $10 is charged upon check out. You are responsible for your deductible, co-pay, and any non-covered or excluded amounts under your policy. If you have in or out of network benefits sometimes payments will be sent to patient. Patient agrees to write a personal check or pay cash for the total amount received by the insurance company payable to BBB Acupuncture Clinic and is fully responsible for unpaid balance. All payments for services rendered are due at the time of treatment. Please be aware that we do have to pay a percentage/portion of the checks received to our billers and upload all EOB's before we get paid out. Make sure you agree to all the terms before signing this contract and allowing for us to bill your insurance.

CANCELLATION POLICY AND TREATMENT PACKAGE AGREEMENT: Boulder Body Balance Acupuncture and Heavenly Massage requests patients to give a 24-hour notice if they are unable to keep an appointment or need to reschedule otherwise the patient will be charged full price for the missed appointment. I understand that if I arrive more than fifteen minutes late for a scheduled appointment or do not give twenty-four hours' notice of a missed appointment that the amount of the entire treatment may be deducted from my prepaid package or I may be charged for the entire amount of the missed appointment. I consent Boulder Body Balance Acupuncture and Heavenly Massage to take payment for and to track the number of visits used for my prepaid treatment packages. I understand that any package deals are non-transferrable, non-refundable*, and expire six months to one year from the date of purchase. This policy is designed for the benefit of both patients and practitioners so that appointments are available to those in need of treatment. I also understand any liens provided by the practitioners/company for the patient pertaining to cases or personal injury cases are fully responsible for the full amount of any unpaid balance. There will be a 5% added fee for unpaid bills after the first year. Boulder Body Balance Acupuncture clinic and Heavenly Massage and its associates can deny or dismiss any treatment if the patient shows inappropriate conduct, safety concerns and any unpaid balances. In the rare circumstance that a refund is given for a partially used treatment package the regular treatment price (not the discounted package treatment price) is deducted from the total amount paid for the package for each treatment used. *** All products sold and treatment completed are non-refundable! I understand that No guarantees of the modalities used in this clinic are made to me and I am free to stop any of the treatments provided at any time.**

Acupuncture/Auricular Medicine/SAAT/Moxibustion/TDP lamp: I understand that acupuncture is performed by the insertion of sterile single use needles through the skin or by the application of heat to 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. Acupuncture and Moxibustion/TDP lamp are typically safe methods of treatment, however certain adverse side effects may result. These could include, but are not limited to: local bruising, bumps, minor bleeding, dizziness, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture or any of the treatments provided at any time.

Pregnancy: I will notify the Acupuncture and Massage Associates should I become pregnant or if I am in the process of trying to become pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

Acupressure/Tui-Na/Shiatsu/Craniosacral/Massage Therapy, Qi Gong/Tai Chi, The Bars: I understand that I may also be given acupressure/tui-na/shiatsu massage and/or Qi Gong/Tai chi as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Bodicurrent/Microcurrent/INOVA/EMSZERO/Acupuncture and any services offered by BBB Acupuncture/Heavenly Massage media release:

I hereby give BBB Acupuncture, its legal representatives, and assignees and those acting with its permission, the right to copyright and/or use, reuse, and/or publish and republish images or video or written testimony of me in any advertising, promotion or public relations involving BBB Acupuncture, and its products without compensation. Due to printing, photographing and reproduction techniques, my image may be slightly distorted in character or form and I do not object to this. I hereby waive any right to inspect or approve the finished picture, advertising copy or other matter that may be used in conjunction with image or video or written testimony of my experience or of me. I hereby release, discharge and agree to save BBB Acupuncture, its representatives, assignees, employees, or any person acting with its permission, from and against any liability as a result or any distortion, alteration or use in composite form of my picture or video or written testimony.

INOVA/EMSZERO: I am aware that pregnancy is contraindicated and pregnant women can't undergo the treatment. I am aware that I can't undergo the treatment when menstruating. Or if any metal implants have been inserted into my body, as this is a contraindication in this treatment procedure, no metals can be in the body. I understand there are certain risks associated with INOVA/EMSZERO treatments and they include but are not limited to: muscular pain, temporary muscle spasm, temporary joint or tendon pain, local erythema or skin redness. I understand that the treatment may involve risks of complications or injury from both known and unknown causes, and I freely assume these risks. I am willing to fill in forms and/or anonymous questionnaires if requested, as this will help for medical evaluation of the results of the treatment. Information will be acquired for medical records or marketing purposes. I understand the results may vary from person to person and that an exact result cannot be predicted. It is very unlikely but it is possible that you will not feel any recognizable result after the procedure. I acknowledge the results may not meet my expectations. I certify that I have read this entire document and that I agree with all provisions. I certify that I have had the opportunity to ask questions and these questions have been answered in full to my satisfaction. I fully understand the treatment conditions, the procedure and possible side effects. I have read the above information, and I request and give my consent to be treated with the INOVA/EMSZERO procedure by the practitioner(s) in the below stated practice and his/her designated staff. My signature certifies that I have duly read, understood the content of this informed consent form, and have given the accurate information as

to my health condition.

Chinese Herbs: I understand that Chinese medicinal herbs 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 but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, nausea &vomiting, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems, which I associate with these substances, I should suspend taking them and call Acupuncture Associates as soon as possible.

Cupping / Gua Sha: I understand that I may also be given cupping (the application of glass cups with vacuum to the skin) and Gua Sha (rubbing of the skin with a smooth object such as a porcelain spoon) as part of my treatment to modify or prevent pain perceptions and to normalize the body's physiological functions. I am aware that these treatments are intended to cause minor bruising and through unsightly are not normally painful. However, certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse the treatment or stop the treatment at any time for any reason I do not expect Acupuncture Associates to be able to anticipate and explain all possible risks and complications of treatment. 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 of anything regarding my treatment. I understand that my records will be kept confidential and will not be released without my written consent (unless in an emergency or by legal demand). I give my permission and consent to treatment.

Evox/Zyto Bioscans: I understand that Zyto and Evox Bioscans are not to treat or cure any illnesses but to balance the imbalance and emotional incoherence of the body.

Injection Therapy: Whenever a needle is introduced through the skin, inherent risks are present. Although the risks are small, the expected benefit from the procedure must outweigh the possible risks. Make sure that you have a thorough understanding of the expected benefit from the injection. The risks of injection depend on where the injection is made and what is being injected. If the injection is made in a large muscle, the risk of hitting vital structures is very small or nonexistent. Injections made in the area of neurovascular bundles (where nerves, veins, and arteries travel together) have a higher risk of injury, and injections in the area of the lung organs have a higher risk of injuring them. Allergic reaction to injected substance: Allergic reactions to homeopathic substances have not been reported, and, in fact, they are used to treat allergic conditions. However, the possibility still exists with any type of injection. *B12 Injections should not be used if: you have allergy to B12, Leber's disease, megaloblastic anemia, or history of blood clots. If you have any of these conditions please let you practitioner know.

The **LIPO-VITE injection** contains Thiamine(B1), Riboflavin(B2), Niacinaimde(B3), Dexpanthenol(B5), Pyridixone(B6), Hyroxycobalamin(B12), Vitamin C, Methionine, L-Carnitine, Inositol, and Choline. **Sensitivity to any of these and/or cobalt, lidocaine, benzyl alcohol or sulfur is a contraindication. *RISK & POSSIBLE EFFECTS- Risk of allergic reaction, tenderness at injection site, infection at injection site as with all injections. We do not recommend anyone under 18 years of age, or anyone with Leber's Disease (hereditary optic neuropathy), and/or Chronic Kidney or Liver Disease receive a LIPO-VITE injection unless a doctor's note has been provided. ***The only patients who would be unable to take LipoVite injections are those that have an allergy to Sulphur. This is because methionine is an enzyme that contains Sulphur. If this is the case, there are other injections you can take for weight loss that do contain essential enzymes and vitamins that do not contain any Sulphur.**

PHYSICIAN INFORMATION

Do you see a medical doctor? If so, name: _____Date of Last Exam:_____ Telephone:_____
Other types of health care: (ie. physiotherapy, massage therapy) _____

MAIN HEALTH CONCERNS

My usual health is: Excellent Good Fair Poor

Please list, in order of importance, your chief concerns:

1. _____
2. _____

Are you comfortable with having therapeutic massage on the following areas: Gluteal region, Abdomen, Pectoral Muscles, Feet, Face, and Head? Please indicate any areas to avoid:_____

CONTEXT OF CARE SUMMARY

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient. The nature of your responses to the following questions will go a long way in assisting my understanding of your truest desires and your constitutional body type. Your honesty in completing this overview will greatly aid us to assist your health needs. Everything will remain confidential.

FAMILY HISTORY

Please circle if any family members, including yourself, have had or currently have:

Cancer Stroke Eczema Asthma Arthritis Thyroid Disease Autoimmune Disease Kidney Stones Allergies Gallstones High/Low Blood Pressure Diabetes Mental illness Liver Disease Heart Disease Addictions Blood Clots Fibromyalgia/Lupus/Lyme Infections Headaches Immune System Deficiencies Insomnia

PAST MEDICAL HISTORY

Childhood illness: (please circle)

Measles German Measles Scarlet Fever Mumps Rheumatic Fever Tuberculosis Chickenpox Ear/Throat Infections Cancer

Vaccinations: (please circle)

Polio Flu MMR(Measles/Mumps/Rubella) Smallpox Hep A and/or B DPT(Diphtheria/Pertussis/ Tetanus) Covid 1 and/or 2 Other:

What hospitalizations, surgeries, x-rays, CAT scans, MRIs, EEGs, or EKGs have you had?

Years: _____ Description: _____

_____

Major accidents/trauma: (falls, motor vehicle accidents, loss of loved one, etc.)

_____

_____

CURRENT MEDICAL HISTORY

Current illnesses, conditions or disease: (if not previously stated above)

_____

_____

Allergies/Sensitivities Write/Circle Below:

Drugs/Food/Chemicals/Oils

Other: _____

Please circle if you are allergic or have a reaction, such as headache, rash, bloating, gas, diarrhea, or any other complaints to any of these substances:

Yeast: Barley, Cherry, Millet, Potatoes, Prune, Raisins, Rye Walnuts

Rice: Cinnamon, Curry, Blueberry, Grapes, Strawberries, Watermelon, Wine, Pumpkin

Wheat: Feathers, Wool, Dust, Detergents, Cat & Dog Dander

Corn

Fats: Meat Fats, Vegetables, Milk Fats, Cosmetics

Oatmeal, Sesame

Milk Cheese

Citrus

Peppers, Peaches, Pears, Plums, Nectrarines

Brewer's Yeast, Rice, Fats, Dairy, Tobacco, Lettuce, Fish, Oils or Ointments, or Any Massage Oils?

<u>Medications & Supplements</u>
Please list any prescription/over-the-counter medications, and vitamins supplements you are currently taking (include dose and frequency):
1. Med/Supp: _____

2. Med/Supp: _____

Height: _____Weight: _____Weight 1 yr ago: _____Maximum weight: _____ Do you eat Organic/Non-GMO foods?

Occupation: _____ Do you enjoy work? Y/N Hours week: _____Hobbies: _____

I hereby request and consent to any of the treatment modalities listed above. I understand the risks involved. I do not expect my practitioner to be able to anticipate all risks and complications. By signing this form, I agree to accept all risks and release all liabilities from Heavenly Massage associates and associates of Boulder Body Balance Acupuncture Clinic, LLC. I also agree to all insurance policies and payment requirements.

I have read and understand and accept the mandatory disclosure and consent information:

Patient Name_____Signature_____Date_____

If under 18 years old, name and signature of consenting parents