

Name _____ Date _____

Colorado Mandatory Disclosure Form - Karl Manteuffel L.Ac.

Education and Experience

Karl Manteuffel earned his Master of Acupuncture degree from Southwest Acupuncture College in Boulder, Colorado in August of 2011. This four-year program consists of 2,525.5 hours of education including 1,000 hours of clinical practice. He was certified as a Diplomat in Acupuncture and Traditional Chinese Medicine by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in September of 2011.

Karl's training includes adjunct therapies such as Asian bodywork therapies of Tui Na and Shiatsu, moxabustion, electric stimulation, injection therapy, cupping therapy, auricular acupuncture, as well as lifestyle and dietary recommendations.

Karl is a member of the Acupuncture Association of Colorado and is a licensed acupuncturist in Colorado. None of these licenses, certificates, or registrations has ever been suspended or revoked.

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

Fee Schedule

- Initial Consultation \$60 - \$100
- 60 Minute Follow-up Treatment \$60- \$100
- 30 Minute Follow-up Treatment \$40 - \$80

Patient's Rights

- The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.™
- The patient may 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 reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Acupuncturists Registration Office, 1560 Broadway, Suite 1350, Denver, Colorado 80202. Telephone (303) 894-2440.

I have read and understand this document. **Signature:** _____ **Date:** _____

Informed Consent to Treatment

I consent to be treated with acupuncture and other procedures associated within Traditional Chinese Medicine and/or substances from the Oriental Materia Medica by Karl Manteuffel, a licensed acupuncturist in the State of Colorado. I have been informed these are safe methods of treatment, but that they may have side effects that could include, but are not limited to: local bruising, minor bleeding, numbness, tingling, fainting, pain or discomfort, and the possible aggravation of existing prior symptoms. Although unusual, there may be a risk of nerve damage, accidental organ puncture, spontaneous miscarriage, infection is a possible risk, although sterile needles and clean fields are used.

Moxibustion is performed by the application of heat to the skin at certain points on the body. If I receive moxabustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs may be recommended to me. I must follow the directions for administration and dosage. I am aware that certain adverse side effects may result from taking these substances that could include: changes in bowel movement, abdominal pain or discomfort, and possible aggravation of symptoms existing prior to treatment. *Should I experience any problems, I should suspend using the substances and call the clinic as soon as possible.* I understand that I may refuse this therapy.

I understand that acupuncturists practicing in the state of Colorado are not primary care providers, and I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

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:** _____