

MANDATORY DISCLOSURE FORM

Good Health Acupuncture & Chinese Herbs, Inc.
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970.663.4548

Disclosure Statement

This Disclosure is in compliance with the State of Colorado, Department of Regulatory Agencies, Colorado Statute Title 12 Article 29.5. All rules and regulations set forth by the Department of health are strictly adhered to by this clinic, including proper cleaning and sterilization of equipment and office. I use only pre-sterilized, disposable acupuncture needles in my practice.

The practice of acupuncture is regulated by the Department of Regulatory Agencies at 1560 Broadway, Suite 1350, Denver, CO 80202. The phone number is (303) 894-7800.

Patients are entitled to receive information about the methods of therapy, techniques used, and the duration of therapy, if known. Patients may seek a second opinion and 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.

24 hour notice required for cancellation. If you are unable to give 24 hour notice, I will do my best to fill your space. If I am unable to do so, you will be charged for the missed visit. All returned checks will be charged a \$20 service fee.

Education, Certification and Experience

In 2004 I received a Master of Oriental Medicine from Southwest Acupuncture College in Boulder, CO (2823 hour 4 year program including the recommendation and application of adjunctive therapies and herbs). NCCAOM Diplomate in Acupuncture issued in 2004. NCCAOM Diplomate in Oriental Medicine (includes Chinese herbs) issued in 2005. I became licensed in the State of Colorado in 2004. My license or certification have never been suspended or revoked. Member of the Acupuncture Association of Colorado. Private practice since 2004.

You agree, by signing this document that all disputes shall be settled by arbitration in accordance with the laws of the State of Colorado, United States of America.

Signature of patient (or guardian) _____ Date _____

Print name _____

Patient's name (if under 18 years old) _____