Tree of Life
Integrative Medicine

826 Camino De Monte Rey suite B2
Santa Fe, NM 87505

Dr. Acazia Gilmore 505.670.3396
Dr. Eric Brunn 505.699.0660

Thank you so much for selecting our practice! In order to serve you properly, we will need the following information. All information will be kept strictly confidential. (Please Print)

Patient Name: _____

Street:_____
City: _____ State (Province): _____
Country:_____ Zip (Postal Code): _____
Home Phone:_____Cell Phone:_____
Work Phone:_____ Email: _____
Date of Birth: ___/___/____(M/D/YR)
Single ___Married ___Divorced ___Separated ___Widowed___ Partnered___

If Child, Parent/Guardian's
Name:_____
Employer:_____
Occupation:_____
Address_____
_____

In case of emergency, please provide us with the name of the nearest relative not residing with you:
Name:_____ Phone:_____
Relationship:_____

I understand that payment is expected at time of service. I am responsible for all charges. If you need a receipt for services rendered please notify your practitioner.

Patient/Guardian Signature_____ Date: ___/___/_____

PATIENT DISCLOSURE AND CONSENT TO TREATMENT

Tree of Life Integrative Medicine offers its patients Acupuncture and Oriental Medicine services, as well as Integrative Manual Therapy ("IMT"). IMT is a unique compilation of diagnostic and treatment methodologies that assess and treat pain, dysfunction and disability. IMT is a new approach to health care developed to address the needs of complex patients. IMT practitioners identify and address the underlying causes of dysfunction using a comprehensive and holistic approach. While IMT diagnostics and treatment modalities are predominately hands on, IMT also integrates a wide range of diagnostic and treatment technologies, nutritional programs (i.e. natural supplements, diet, and herbs), and IMT body based psychotherapeutic approaches to develop a customized solution for an individual patient's needs.

By choosing Tree of life Integrative Medicine, I _____ acknowledge that I have a general understanding of IMT that I learned from a combination of discussions with a Tree of Life Therapist, and/or other associated websites. I acknowledge that I have elected to be treated by a therapist trained in IMT. I further acknowledge that while there will be an ongoing assessment of my treatment and condition, I recognize that, over time, my symptoms may not change, and furthermore that their is no guarantee of positive improvement of my condition. I will, however, be evaluated on an ongoing basis, and your treatment plan will be presented to you so that you may choose to continue or end treatment at your discretion.

I further understand that payment for the IMT therapeutic services I receive is my responsibility and such services are generally not covered by health insurance plans. I have discussed and fully understand the clinical and reimbursement principles of IMT and elect to receive IMT therapeutic services voluntarily and with full knowledge of the benefits, risks and differences between IMT therapeutic services and traditional treatment.

I hereby request and consent to the performance of Acupuncture and Oriental Medicine treatment(s), on me (or on the patient named below for whom I am legally responsible) by a Doctor of Oriental Medicine (D.O.M.) employed by Tree of Life Integrative Medicine.

I understand that methods of treatment may include, but are not limited to, Acupuncture, Massage Therapy(ies) including TuiNa, moxibustion, cupping, electrical acupoint stimulation, traditional herbal medicine(s), nutritional counseling and/or nutritional supplementation. I understand that the herbal products prescribed may need to be prepared and consumed according to the instructions provided verbally and in writing. I realize that the herbs may have an unpleasant smell or taste. I will immediately notify my Provider or a member of his/her clinical staff in the case of any unanticipated or unpleasant effects associated with the consumption of herbs or other nutritional supplements. I am informed that Acupuncture, MyoFascial Release / Massage Therapy are generally safe methods of treatment, but that they may have some side effects, including bruising, numbness or tingling near the treatment sites that may last up to a few days, and in rare cases dizziness or even fainting. Bruising is a common and often intended effect of cupping and gua sha. Unusual risks of acupuncture include spontaneous miscarriage,

nerve damage, and organ puncture, including lung puncture (pneumothorax); infection is another possible risk, although the Clinic exclusively uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects or risks may occur. The herbs and nutritional supplements used by my Provider (which are from plant, animal, and mineral sources and include any herbal or homeopathic medicine, vitamins, enzymes, glandular products, live cell products, amino acids, gerovitals, and OTC dietary/nutritional supplements) are considered safe in the practice of Oriental Medicine and/or are within the scope of practice for a D.O.M. licensed in the state of New Mexico.

I do not expect my Provider to be able to anticipate/explain all possible risks and complications of treatment, and I wish to rely on him/her to exercise judgment during the course of treatment which is at the time, based upon the facts then known, believed to be in my best interest. I understand results are not guaranteed, and I can refuse any aspect of treatment any time. I consent for my Provider to order and/or review lab tests or reports, knowing that all my records will be kept confidential according to the law, and will not be released without my written consent. I also understand my Provider is not providing Western (allopathic) medical care, and that I should look to my primary care practitioner (i.e. MD, PA or CNP) for those services. By voluntarily signing below, I show that I have read, or have had read to me, the above consent for treatment, understand the risks and benefits of said treatment(s), and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and any future condition(s) for which I may seek treatment.

_____ _____

Patient/Guardian Signature Date