DISCLOSURE STATEMENT AS REQUIRED UNDER SB-215 FOR COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTITIONERS IN COLORADO

- 1. Practitioner Name:
- 2. Practitioner Business Address:
- 3. Practitioner Phone Number:

As a Complementary and Alternative Health Care Practitioner, I am not licensed, certified or registered by the state of Colorado as a health care professional. I am not a licensed medical physician and do not diagnose, treat or prescribe remedies for the treatment of disease. The services I perform, whether in person, by mail or by phone, are at all times restricted to complementary and alternative health care services intended for the maintenance of the best possible state of nutritional health. I am prohibited from performing surgery or any invasive procedure, administer or prescribe x-ray radiation, prescribe prescription drugs, use general or spinal anesthetics, administer ionizing radioactive substances, use a laser device that punctures the skin, perform enemas/colonics unless board certified, practice midwifery, practice psychotherapy, perform spinal manipulation, practice optometry, directly administer medical protocols to a pregnant woman or a person who has cancer, practice dentistry, set fractures, practice massage therapy, provide a conventional medical disease diagnosis or recommend the discontinuation of a course of care recommended by a health care professional. I am also prohibited from treating children less than two years of age. In order to treat a child who is between 2-8 years of age, I must have a written, signed consent of the child's parent or legal guardian:

protocols to a pregnant woman or a person who has cancer, practice dentistry, set fractures, practice massage therapy, provide a conventional medical disease diagnosis or recommend the discontinuation of a course of care recommended by a health care professional. I am also prohibited from treating children less than two years of age. In order to treat a child who is between 2-8 years of age, I must have a written, signed consent of the child's parent or legal guardian:	
Name of Child (Age 2-8)	Signature of Parent/Legal Guardian
The services I provide are as follows:	
My professional degrees, training, experien	ice, credentials and qualifications are as follows:
	ole to any injury caused by an act or omission in providing complementary y of this disclosure statement will be kept on file for at least two years after
•	nmendations I provide with your Primary Care Physician, Obstetrician, atrician or Pediatric Health Care Provider, or other Board-Certified Physician.
Name of Client	Signature of Client
Address of Client	City, State, Zip Code
Phone Number	E-Mail Address
Date of Birth	Date of First Visit