Grace Acupuncture and Herbs, PLLC
Lisa Megumi Boyle L.Ac., Dipl.O.M.
14850 Lake Hills Boulevard Suite B4, Bellevue WA 98007
(425) 208-1972

First Name:	Last Name:	Male/Female
Address:		
City:	State:	Zip:
Phone:		
Email:		
Date of birth:	Age:	
Marital status:		
Emergency contact:	Relationship:	Phone:
Family physician:	Phone:	
How did you hear about us?		

We value your privacy and from time to time we send out email, text and mail communication updates, some may be important and timely, Would you like to receive:

Emails: ☐ Yes ☐ No
Texts: ☐ Yes ☐ No
Mail: ☐ Yes ☐ No

Please describe the main reason for your visit today:

_____

_____

To what extent does it interfere with your daily activities?

_____

_____

Please indicate if you have any of the following:

- Cardiac pacemaker
- Seizure disorder
- Bleeding disorder/ Blood thinners
- Fainting disorders
- High blood pressure
- Believe you are or may be pregnant
- HIV/AIDS positive
- Hepatitis
- Tuberculosis
- Other:_____

List all major childhood and adult illnesses:

_____

_____

Have you had any surgeries, major accidents or injuries, please explain:

_____

_____

List any major disease or illness in your immediate family and indicate family member:

_____

_____

List all medications or supplements, including herbs and vitamins you are currently taking:

_____

_____

Occupation:_____

Do you have a regular exercise program?_____
Please describe:

_____

_____

Are you on a restricted diet? What kind?_____

_____

_____

How much sugar/dessert do you eat per week?

_____

How much dairy do you eat per week?

_____

How many packs of cigarettes do you smoke per week?

_____

How much coffee, tea, or cola do you drink per week?

_____

How much alcohol do you drink per week?

_____

Do you do any drugs? How much per week?

_____

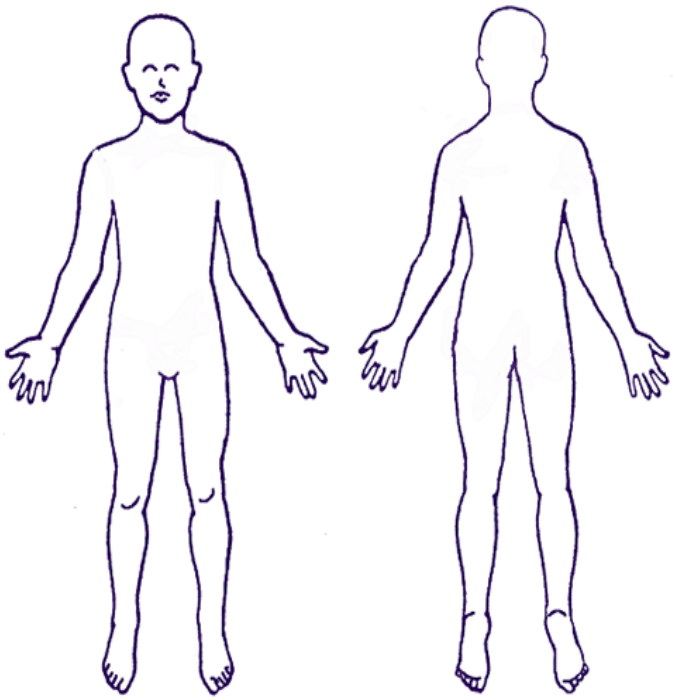
Do you have any known allergies?

_____

Please use the following key to indicate painful or distressed areas. Please rate pain on a scale of

1 (No pain) to 10 (Worst pain).

XXX Sharp/stabbing
PPP Pins and needles
NNN Numbness
DDD Dullness



PATIENT MEDICAL SYMPTOMS

Please check all symptoms that pertain to you at the current time.

□ Cold hands/feet
□ Fatigue
□ Feverish in the afternoon or flushes
□ Heat sensation in hands, feet, chest
□ Night sweats
□ Catch colds easily
□ Sweats easily during daytime
□ Dizziness
□ See floating black spots

_____

□ Palpitations
□ Sore on tongue
□ Restlessness
□ Anxiety
□ Chest pain
□ Insomnia

_____

□ Cough
□ Sinus congestion
□ Dry mouth, throat, nose, or skin
□ Allergies seasonal or food
□ Chills and fever
□ Stiff neck/shoulders
□ Sore throat
□ Difficult breathing

_____

□ Low appetite
□ Loose stools
□ Constipation
□ Abdominal bloating or gas after eating
□ Feeling tired after eating
□ Prolapsed organs (previously diagnosed)
□ Bruises easily
□ General feeling of heaviness in body
□ Mental heaviness or fogginess
□ Swollen hands/feet
□ Burning sensation after eating
□ Bad breath
□ Large appetite
□ Mouth, canker or cold sores
□ Bleeding, swollen or painful gums
□ Heartburn/belching
□ Stomach pain
□ Vomiting/nausea
□ Diarrhea alternating with constipation

□ Tight/suffocating feeling in chest
□ Bitter taste in mouth
□ Blood shoot eyes/dry eyes
□ Anger easily
□ Skin rashes
□ Headache
□ Numbness of hands and feet
□ Muscle spasms, twitching, cramping
□ Seizures/convulsions
□ Sore, cold or weak knees
□ Low back pain
□ Frequent urination
□ Get up more than once a night to urinate
□ Lack of bladder control
□ Memory problems
□ Hair loss
□ Ringing in ears

Urine is:

□ Normal color □ Clear
□ Dark yellow □ Reddish
□ Cloudy □ Scanty
□ Bad odor
□ Burning □ Painful
□ Difficult □ Urgent

Libido (sex drive) is:

□ Normal □ Low □ High

Women only:

- Are you pregnant now?

□ Yes □ No

- Number of children:_____
- Number of pregnancies:_____
- Age of first period:_____
- Age of menopause if applicable:_____
- Is your menses cycle regular?

□ Yes □ No

a. Average number of days in flow:____

b. The flow is:
□ Normal □ Heavy □ Light

c. The color is:
□ red □ dark □ purple
□ light brown □ brown

d. Do you have the following menstruation related symptoms?

□ Blood clots
□ Cramps
□ Nausea
□ Breast distension
□ PMS
□ Bleeding between periods
□ Heavy vaginal discharge between periods

e. Birth control:_____

Men Only:

□ Discharge

□ Pain or swelling of testicles

□ Ejaculatory problems

□ Impotence/erectile dysfunction

Signature _____

Date_____

OFFICE FINANCIAL POLICY AND AUTHORIZATION TO BILL INSURANCE

There are two billing options available for you. Please select the one you prefer us to use for your visits. If at any time if you choose to change your billing option, you are required to let us know immediately and sign a new Office Financial Policy and Authorization to Bill Insurance Form.

_____ Private Pay

Private Pay patients are patients that do not bill insurance. **This discounted cash rate is only applied to the published rate if you pay at the time of service.**

_____ Insurance Billing (Medical or Auto Insurance)

Regarding insurance:
We will verify coverage prior to treatment and we will file all claims as a courtesy to you. If for any reason we are not able to verify coverage prior to your treatment, you will be charged for the treatment until verification is obtained. We cannot bill your insurance unless you bring us all necessary insurance information. We are not a party to that contract. By signing this document, you are assigning to this office the benefits to which you are eligible to receive for care rendered in this office. Additionally, in signing this document you authorize the release of any information to any insurance company, adjuster or attorney that will assist in the payment of a claim. We request a credit card on file if the insurance company should not pay claims or any balances owed should there be any difference in the amount owed.

I understand that I must pay all co-payments and/or co-insurances not covered by my insurance company at the time of check in for today's visit, and every visit hereafter. Grace Acupuncture and Herbs will submit my claim for me to my insurance company. Although Grace Acupuncture and Herbs verifies my insurance; **I understand that this verification is not a guarantee of payment.** I understand that any and all charges incurred at this office including co-payment, co-insurance, percentage due and/or deductibles or any other fees or services not covered by my insurance company are **my responsibility. I understand that if these patient portions due are not paid at the time of service I will be subject to a $10.00 billing fee per month – no exceptions until the outstanding amounts are paid.** I further understand that any unpaid balance **over 90 days**, can and will be sent to collections for recovery unless prior arrangements have been made.

I authorize my insurance benefits to be paid directly to Grace Acupuncture and Herbs. I also authorize the provider to release any information and medical records required by my insurance company. I understand that I may revoke this consent by written request, at any time. No other records shall be released without my signed consent.

_____ _____
Signature of Responsible Party Date

_____ _____
Signature of Person Authorized to Consent Date

NOTICE OF PRIVACY POLICIES

Grace Acupuncture and Herbs, PLLC

Our office is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

We gather personal information and health information in several ways;

- Information we receive.
- Information we receive from other healthcare providers.
- Information we receive from third party payers.

This information is used for treatment, payment and healthcare operations.

You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for the treatment, payment, and healthcare operations.

You may specifically authorize us to use protected health information for any purpose or to disclose our health information by submitting the authorization in writing. Such disclosures will be made to any personal representation you choose to have your protected health information.

Marketing

This office will not use your health information for marketing communications without your written authorization. This office may send birthday cards, newsletters and appointment reminder, by calls, post cards or letters.

Disclosure

This office may use or disclose your Protected Health Information when required by law..

Patient Rights

Upon written request you have the right to access, review or receive copies of your healthcare records.

Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.

You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.

You have the right to request that we amend your Protected Health Information; the request must be in writing.

You have a right to receive all notices in writing.

If you have questions, complaints or want more information please contact Lisa Megumi Boyle, L.Ac. at telephone: (425) 208-1972.

You may also send a written complaint to the U.S. Department of Health and Human Services:

DHHS (Office of Civil Rights)
200 Independence Ave S.W. Room 509 F HHH Building
Washington, DC 20201

Kneady Body & Feet Association Privacy Notice

Clinic Policy—We are a cooperation of multiple businesses each with state licensing and insurance. We each operate a contracted business in cooperation with Kneady Body & Feet Massage LLC.

We are a HIPAA compliant office. Your privacy is important to us. Your personal information will be protected within our clinic and not shared with anyone outside of Kneady Body & Feet Association.

Patient Responsibility: You agree to communicate with your practitioner immediately about any conditions or techniques during your work together that do not enhance your well-being. Failure to communicate all of your medical conditions may further damage your health. Any actions that may be construed as sexual advances or unsafe behavior will be reported to the police station without discussion.

Cancellations and No Shows—In effort to provide all of our clients with outstanding service, 24 hours notice is required for all cancellation notices and rescheduling requests. Payments are due upon receipt of the invoice.

I have read and understand the privacy policies of Grace Acupuncture and Herbs and Kneady Body & Feet Wellness Center. I understand omitting any information could lead to further physical/emotional complications after receiving any type of bodywork. I acknowledge that my practitioner is not licensed to diagnose any condition and it is my sole responsibility to ensure the safety of my health.

_____ _____

Signature Date