

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?

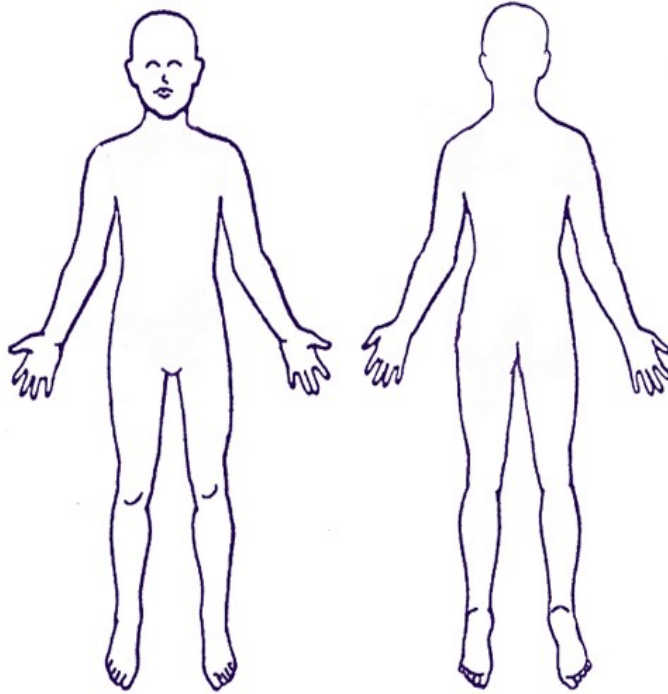
How much alcohol do you drink per week?

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 foginess
 - 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:
- | | |
|---------------------------------------|----------------------------------|
| <input type="checkbox"/> Normal color | <input type="checkbox"/> Clear |
| <input type="checkbox"/> Dark yellow | <input type="checkbox"/> Reddish |
| <input type="checkbox"/> Cloudy | <input type="checkbox"/> Scanty |
| <input type="checkbox"/> Bad odor | |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Painful |
| <input type="checkbox"/> Difficult | <input type="checkbox"/> Urgent |
- Libido (sex drive) is:
- | | | |
|---------------------------------|------------------------------|-------------------------------|
| <input type="checkbox"/> Normal | <input type="checkbox"/> Low | <input type="checkbox"/> 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

Effective Date: 02/16/2026

This Notice explains how your health information may be used and disclosed and how you can access it. Please review it carefully.

OUR RESPONSIBILITIES

We are required by law to protect the privacy and security of your Protected Health Information ("PHI"). We must follow the privacy practices described in this Notice and provide you with a copy upon request.

HOW WE USE AND SHARE YOUR INFORMATION

We may use and share your health information for:

- **Treatment** - providing and coordinating your care
- **Payment** - billing and payment activities
- **Health Care Operations** - administrative, quality, and business operations

We may also use or disclose your information as required or permitted by law, including for public health, legal, safety, and oversight purposes.

USE OF TECHNOLOGY

We use electronic systems and technology-assisted tools to support scheduling, documentation, billing, record keeping, and other operational functions. These tools support – and do not replace – professional clinical judgment. Your information is protected and used only as allowed by law.

INFORMATION ABOUT SUBSTANCE USE

If clinically relevant, we may document information related to medications, alcohol, or other substances. This information is treated as standard Protected Health Information under HIPAA. We do not operate as a Substance Use Disorder treatment program.

YOUR RIGHTS

You have the right to:

- Access and obtain a copy of your health records
- Request corrections
- Request confidential communications
- Request limits on certain uses or disclosures
- Receive a list of certain disclosures
- Obtain a paper copy of this Notice
- File a complaint if you believe your privacy rights have been violated

CHANGES TO THIS NOTICE

We may update this Notice from time to time. The current version will always be available upon request and on our website.

QUESTIONS OR COMPLAINTS

If you have questions or concerns about your privacy, please contact:

Name: Lisa Megumi Boyle

Phone: (425) 208-1972

Email: lisamboylelac@graceacusherbs.com

You may also file a complaint with the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

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

