Ponderay Acupuncture Boundary Acupuncture Nelson Ivan Comerci L.Ac. ACU-288

First Name:_____ **MI:**_____ **Last Name:**_____ **Date:** _____

Mailing Address: _____

Cell: _____ **Home:** _____

Email:_____

Date of Birth: _____ **Gender Male:** _____ **Female:**_____ **Other:** _____

Emergency Contact Name: _____ **Phone:** _____

Physician's Name Name: _____ **Phone:** _____

How did you hear about our clinic?

Health Care Provider (who?):	_____	**Friend / Family**	_____
Advertisement (where?):	_____	**Internet**	_____
Phone Book:	_____	**Other**	_____

Which covid vaccinations have you had in the past?

Pfizer-BioNTech	☐	Date(s):_____
Moderna	☐	Date(s):_____
Novavax	☐	Date(s):_____
Johnson & Johnson	☐	Date(s):_____
AstraZeneca-Oxford	☐	Date(s):_____
Other	☐	Date(s):_____
None	☐	

CURRENT HEALTH

What are the 3 main symptoms / problems you are seeking treatment for? How long have you had them?

_____

_____

_____

_____

_____

Diagnoses you have been given by physicians:

_____

_____

_____

Have you had any treatment, surgery or hospitalization for your main complaints?

_____

_____

_____

WESTERN MEDICAL DIAGNOSIS

Please check of any you have now or have had in the past:

Diabetes _____ Stroke _____ Heart Attack _____ Pacemaker _____

Arthritis _____ Multiple Sclerosis _____ Epilepsy / Seizures _____

Allergies _____ Cancer / what type? _____

Fibromyalgia _____ Chronic Fatigue Syndrome _____ Mental Health Issues _____

Other _____

Hepatitis B _____ Hepatitis C _____ HIV / AIDS _____ TB _____

DIAGNOSTIC QUESTIONS

PLEASE INDICATE ALL SYMPTOMS YOU HAVE EXPERIENCED WITHIN THE PAST 30 DAYS. PLEASE CIRCLE ACCORDING TO SEVERITY OF SYMPTOMS

L = LIGHT M = MEDIUM S = STRONG

HEAD, EYES, EARS, NOSE, THROAT

L M S sinus problems | L M S nose bleeds | L M S dry mouth

L M S difficulty swallowing | L M S sore throat / mouth | L M S thrush / leukoplakia

L M S headaches | L M S dental / gum | L M S thirst

L M S ear / hearing | L M S vision problems | L M S dizziness

L M S sneezing/runny nose | L M S other (specify) _____

RESPIRATORY

L M S short of breath | L M S pain w/deep breath | L M S phlegm

L M S blood in sputum | L M S wheezing | L M S cough

L M S bronchitis | L M S frequent colds | L M S chest pain

L M S other (specify) _____

GASTROINTESTINAL

L M S loss of appetite | L M S abdominal cramps | L M S nausea

L M S gas/bloating | L M S constipation | L M S diarrhea

L M S weight loss | L M S hemorrhoids | L M S vomiting

L M S heartburn | L M S jaundice | L M S other (specify) _____

CARDIOVASCULAR

L M S low blood pressure | L M S high blood pressure | L M S palpitations

L M S angina | L M S fast heart rate | L M S slow heart rate

L M S atrial fibrillation | L M S congestive heart failure

L M S other (specify) _____

GENITO-URINARY

L M S frequent urination L M S night urination L M S impotence

L M S low sex drive L M S pain L M S edema / swelling

L M S genital sores L M S genital warts L M S other (specify) _____

MUSCULAR / SKELETAL

L M S muscle / joint pain L M S back pain L M S weakness

L M S pain, tingling or numb arms, legs, fingers, toes / neuropathy

L M S stiff neck / shoulders L M S other (specify) _____

NEUROLOGICAL / PYSCHOLOGICAL

L M S depression L M S anxiety L M S fear

L M S irritability/anger L M S disorientation L M S forgetfulness

L M S tremors L M S insomnia L M S seizures

L M S poor concentration L M S bipolar L M S other (specify) _____

SKIN / HAIR / NAILS

L M S itchy/painful rashes L M S fungus L M S shingles

L M S psoriasis/eczema L M S mole changes L M S cold sores

L M S hair loss L M S acne L M S bleed/bruise easily

L M S other (specify) _____

OTHER SYMPTOMS

L M S fever over 100 L M S night sweats L M S fatigue

L M S swollen lymph nodes L M S chills L M S day sweats

L M S glucose intolerance L M S other (specify) _____

GYNECOLOGICAL / OBSTETRICS

L M S yeast infections **L M S menstrual cramps** **L M S clots**

L M S pelvic infections **L M S spotting** **L M S PMS**

L M S mid-cycle pain **L M S irregular periods** **L M S no periods**

L M S vaginal discharge **L M S vaginal pain/itch** **L M S hot flashes**

L M S other (specify) _____

Menstrual Info: _____ days bleeding _____ day cycle Date of last period: _____

Do you take Hormone Replacement Therapy?_____

Are you pregnant? _____ Please alert your practitioner if you become pregnant.

Your treatment will be modified to support a healthy pregnancy.

Are you in menopause? _____

How many pregnancies have you had? _____ Cesareans? _____

Date of last pap smear?_____ Normal_____ Abnormal_____

Last breast exam? _____ Normal _____ Abnormal _____

MEDICATIONS / SUPPLEMENTS / HERBS

PLEASE LIST ALL MEDS / SUPPLEMENTS / HERBS YOU TAKE:

PRODUCT USED TO TREAT SIDE-EFFECTS EXPERIENCED

1._____

2._____

3._____

4._____

5._____

6._____

7._____

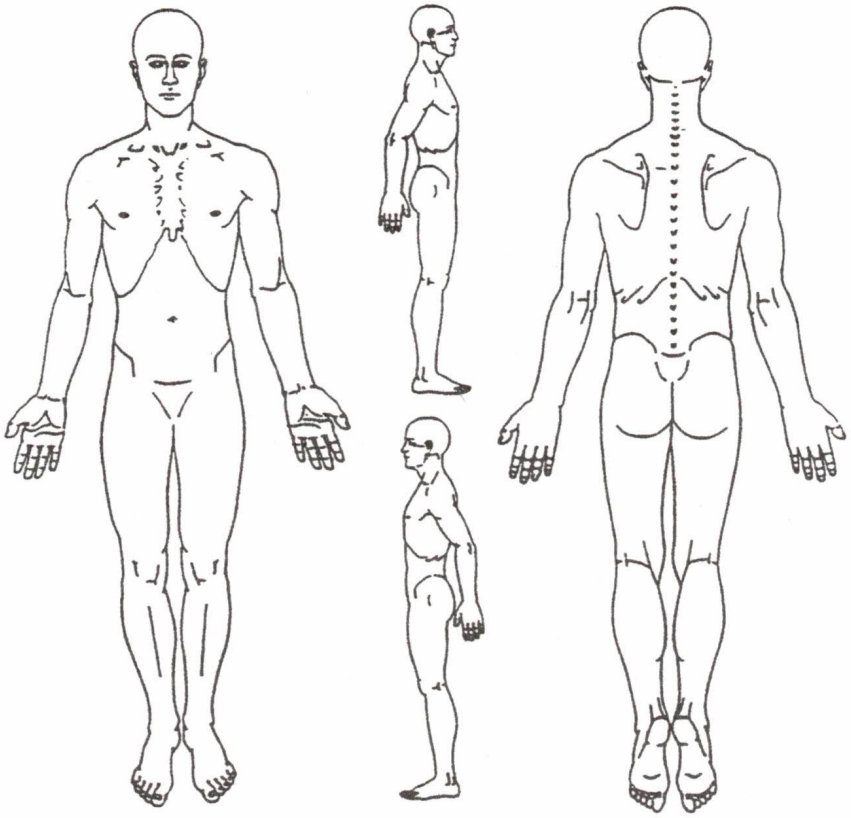
8._____

9._____

10._____

LOCATE THE PAIN ON THE MAP USING THE SYMBOLS

Aching	∿∿∿	Burning	X X X X X
Sharp	/ / / / / /	Pins & Needles	. . . . . .
Numb	0 0 0 0 0	Shooting or Moving	↑↓



Circle number which best describes your average pain level (0 = no pain 10 = Emergency Room)

Neck	0 1 2 3 4 5 6 7 8 9 10	Right Arm	0 1 2 3 4 5 6 7 8 9 10
Upper Back	0 1 2 3 4 5 6 7 8 9 10	Left Arm	0 1 2 3 4 5 6 7 8 9 10
Mid Back	0 1 2 3 4 5 6 7 8 9 10	Right Leg	0 1 2 3 4 5 6 7 8 9 10
Lower Back	0 1 2 3 4 5 6 7 8 9 10	Left Leg	0 1 2 3 4 5 6 7 8 9 10

How long can you sit?_____ stand?_____walk?_____drive?_____

Do symptoms interfere with sleep?_____

ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not. I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling.

I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses.

I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue. While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest.

I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure. I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter).I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit. By voluntarily signing below, I confirm that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I agree with the current or future recommendations for care. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

TERMS AND CONDITIONS

I understand there is a 24 hour policy for cancellations and rescheduling which must be done by phone. I understand that there is a $55 fee for late cancellations and rescheduling or failing to show up for a confirmed appointment. Please understand that it is your responsibility to remember your appointment dates and times in order to prevent any missed appointments which result in a cancellation fee. Not receiving an electronic notification of your appointments from us the day before is not sufficient reason to miss an appointment. Emergency absences will be considered on an individual basis. Treatment is due upfront at time of service. There is no refund for herbal prescriptions or supplements.

CONSENT TO LEAVE MESSAGES /SHARE INFORMATION WITH FAMILY & FRIENDS

I understand that my healthcare information is protected. I understand that in some circumstances our office may have to talk with a family member or a friend about your treatment or health information. By signing below you give permission for messages to be left on your phone number(s), text messages or email reminders for appointment reminders/changes, account payments/balances, cost estimates, deeded treatment/completed treatment and/or herbal information.

Under the HIPAA Privacy Law we are permitted and we may make a professional judgment that certain disclosures are in your best interests even without this signature. I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information Form.

By voluntarily signing below I show that I have read this consent to treatment, terms and conditions and have had the opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition(s) and any future condition(s) for which I seek treatment.

_____

SIGNATURE PRINT DATE

_____

SIGNATURE OF REPRESENTATIVE PRINT OF REPRESENTATIVE DATE

INSURANCE INFORMATION FORM

Patient's Full Name:_____Male:_____Female:_____Other:_____

Primary Phone:_____Date Of Birth:_____

Mailing Address:_____

Physical Address:_____

Spouse's / Partner's Name:_____Phone:_____

Patient Insurance Information

Primary Insurance Company:_____

Policy Holder's Name:_____Date of Birth:_____

Member ID #:_____Group #:_____

Relationship to Subscriber/Policy Holder: Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance Company:_____

Policy Holder's Name:_____Date of Birth:_____

Member ID #:_____Group #:_____

All professional services rendered are charged to the patient, necessary forms will be completed to help expedite insurance carrier payments. I understand and agree that I am financially responsible for all charges for any and all services rendered. I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance. I understand and agree that it is my responsibility to know if my insurance has any deductible, co payment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full. I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full. I do hereby attest that the forgoing information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or, concealment of material fact may subject me to administrative, civil, or criminal liability. Should this account be referred to an attorney and/or third party for collection, the undersigned shall pay all collection fees/expenses. I AUTHORIZE NELSON IVAN COMERCI L.Ac. TO RELEASE MY INSURANCE COMPANY, THIRD PARTY, MEDICAL FACILITY OR ATTORNEY ANY MEDICAL INFORMATION NECESSARY TO EXPEDITE MEDICARE CARE, AND/OR INSURANCE COVERAGE. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO NELSON IVAN COMERCI L.Ac. FOR SERVICES PROVIDED. This authorization shall be in force and effect until the death of the patient, at which time this authorization form expires. The responsibility for the payment of all account balances belongs to the individual identified as the guarantor. This is normally the patient except for minors or other dependents. There is no exception to this rule. We will bill insurance as a courtesy and therefore, the guarantor is ultimately responsible for any unpaid or denied services. I UNDERSTAND THAT THE OFFICE OF NELSON COMERCI L.Ac. DOES NOT BILL MEDICARE OR MEDICAID. By signing below, I acknowledge the policies stated above.

_____

Signature of patient or authorized person Printed name Date