# Blue Buddha Acupuncture Intake Form

| Joy Blais L.Ac. (503) 855-9429 / 11845 SW Greenburg Rd Suite 120 Tigard, OR 97223 | | | |
|---|---|---|---|
| **Today's Date** | | | |
| **Patient Name** | | **Gender Identity** | |
| **Date of Birth** | | **Current Age** | |
| **Email Address** | | | |
| **Mailing Address** | | | |
| **City, State & Zip** | | | |
| **Cell Phone #** | | **Ok to leave health related voicemail? Y or N** | |
| **Home Phone #** (if different) | | **Ok to leave health related voicemail? Y or N** | |
| **Emergency Contact Name & Phone** | | | |
| **Primary Care Physician Name & Phone (if known)** | | | |
| **Employer Name** | | | |
| **Insurance & Policy #** | | | |
| **How did you hear about me?** (web, friend, sign, etc.) | | | |

**Chief Concern/Reason for Seeking Treatment:** ______________________________

________________________________________________________________

**Please explain your concern including when the issue started, how it affects your life, what medical diagnosis you have been given, what kinds of treatment you have tried.** ___________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

**Secondary Concerns:**___________________________________________________

________________________________________________________________

**Medicines/Drugs /Herbs /Vitamins you are currently taking including dose and reason for taking them (use back of page if needed):**

________________________________________________________________

________________________________________________________________

________________________________________________________________

| **Today's Date** | | | |
|---|---|---|---|
| **Patient Name** | | **Date of Birth** | |

**Allergies (drugs, foods, environmental, etc.):**_____________________________

**How do you view your current state of health?** Poor Fair Good Excellent

Smoke cigarettes (how many/day)_______________ Drink alcohol (how often)?_______________

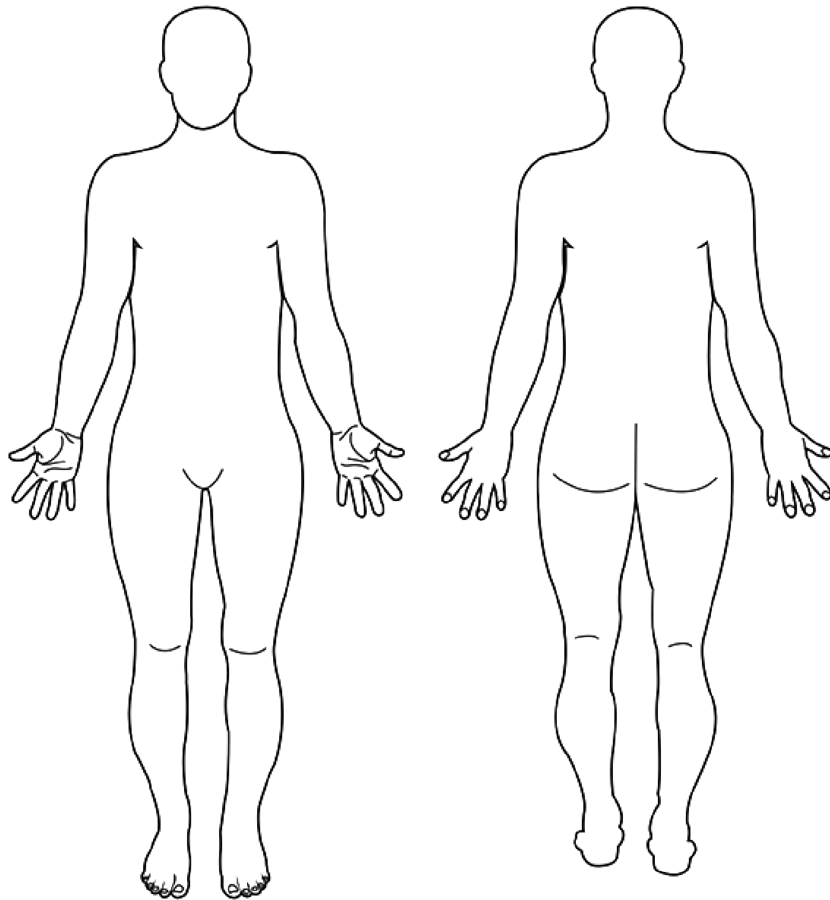
Recreational drugs (how often)?_______________ Drink coffee (how often)?_______________

Drink water (how much)?_______________ Exercise (kind & amount)?_______________

What do you do to relieve stress?_______________________________________________

Current Height_______________ Current Weight_______________ Current Blood Pressure_______

**Please shade any areas of pain on the body map below:**



# Patient Consent Form

| **Patient Name** | | **Date of Birth** | |
|---|---|---|---|

**I, the undersigned, acknowledge the following:**

1) I understand that receiving acupuncture involves insertion of thin sterile needles into the skin to treat specific health concerns. No guarantee has been given to me concerning the cure or improvement of my condition and I am free to seek or continue care with other physicians, surgeons, practitioners, and health care providers at any time. I have also been given the opportunity to ask any questions regarding treatment.

2) I understand that in addition to benefits, there are potential risks of receiving treatment which include but are not limited to: temporary skin discoloration, bruising, mild burning from moxibustion (if used), temporary discomfort, nausea, dizziness, fatigue, headache, or aggravation of symptoms.

3) I understand that all fees are due on the day of treatment. If using insurance, I agree to pay my copay as well as any fees billed to me (such as a co-insurance percentage, deductible charges, etc.) in accordance to the stipulations of my insurance plan. I understand that I have 30 days to pay any invoiced fees, after which a monthly late charge will accrue on my account. I also understand that insurance benefit information is provided to me as a courtesy but I am ultimately responsible for any charges incurred and if I am unsure of my coverage I should contact my insurance company directly for accurate information. By signing below, I acknowledge that Joy Blais L.Ac. is not responsible for misinformation given to her by insurance representatives regarding my benefit plan.

4) I understand that it is my responsibility to keep track of the day and time of my appointment. Should I need to cancel or reschedule, I agree to do so at least 24 hours in advance via telephone or text (please do not cancel via email). By signing this consent form **I agree to pay an $85 fee for all missed appointments not canceled at least 24 hours in advance and I agree to provide a credit card number to be kept on file for this purpose.**

5) **I understand that a $2 fee is charged for all in person credit card transactions including from HSA (health savings accounts) and a $3 fee is charged for manual credit card entry (if the card is not present).** The is no additional fee for check or cash payments.

I hereby authorize and consent to the above provisions and to treatment by Joy Blais L.Ac.

______________________________ ____________

**Patient Signature** **Date**

______________________________ ____________

**Legal Guardian Signature (if under 18 years old)** **Date**

**This form is required for all patients. Please complete all fields.**

I, ______________________, authorize Joy Blais L.Ac. to charge my credit card
(your name)
above for the agreed upon fee in case of a no-show or cancellation within 48 hours of my acupuncture appointment. I understand that being more than 20 minutes late for my appointment is considered a no-show. I also authorize use of this credit card for any balance on my account that is overdue (not paid within 30 days of invoicing) with a $3 processing fee. I understand that my credit card information will be saved to file for this purpose.

________________________________ ________________________
Customer Signature Date

**Credit Card Information**

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other ____________

Cardholder Name (as shown on card): ____________________________________

Card Number: ______________________________________________________

Expiration Date (mm/yy): ________________ CVV Code (3 or 4 digits)__________

Cardholder ZIP Code (from credit card billing address): ______________________