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			
Mailing Address			
City, State & Zip			
Cell Phone #		**Ok to leave health related voicemail on this line? Y or N**	
Home Phone #		**Ok to leave health related voicemail on this line? Y or N**	
Date of Birth		**Current Age**	
Email Address		**Gender Identity**	
How did you hear about me? (web, sign, etc.)			
Primary Care Physician		**PCP Phone # (if known)**	
Emergency Contact		**Emergency Contact's #**	
Employer Name			
Insurance & Policy # (only if using insurance)			

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:

_____
_____
_____

Patient Name	

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 soda (how often)?_____ Drink water (how much)?_____

Exercise (kind & amount)?_____ What do you do to relieve stress?_____

Current Height_____ Current Weight_____ Current Blood Pressure_____

Please circle your current concerns and check ✓ those you have had in the past:

Accidents	Depression	Hepatitis	Muscle Weakness	Skin Problems	Weight Changes
Allergies	Diabetes	High Blood Pressure	Night Sweats	Sleeping Problems	Other (explain):
Anemia	Digestive Problems	HIV/AIDS	Pain	STDs	
Anxiety	Emotional Concerns	Incontinence	Painful Menses	Stroke	
Asthma	Extended Illness	Irregular Periods	Panic Attacks	Thyroid Issues	
Bleeding	Headaches	Lung Issues	Recurring Infections	Trauma	
Breast Problems	Hearing Problems	Menstrual Issues	Rheumatic Fever	Urinary Problems	
Cancer	Heart Issues	Mononucleosis	Seizures	Vision Problems	

Provide Family History Information (Problems that run in your family):

_____

_____

***Menstruation, Pregnancy, & Menopause*:**

Age of first menses_____ # of pregnancies _____ #of live births_____

Currently pregnant? _____ Currently on hormonal birth control?_____

Any problems with menstruation (past or present)? Explain:_____

Are you post-menopausal? _____ If yes, what age was menopause? _____

Patient Consent Form

Patient Name	

I, the undersigned, acknowledge that I have been informed of and understand the following:

1) I understand that 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.

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 re: my benefit plan.

4) I understand that it is my responsibility to keep track of the day and time of my appointment and 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 a $65 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 24 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): _____