

## Blue Buddha Acupuncture Intake Form

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

**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):**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<b>Today's Date</b>			
<b>Patient Name</b>		<b>Date of Birth</b>	

**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)? \_\_\_\_\_

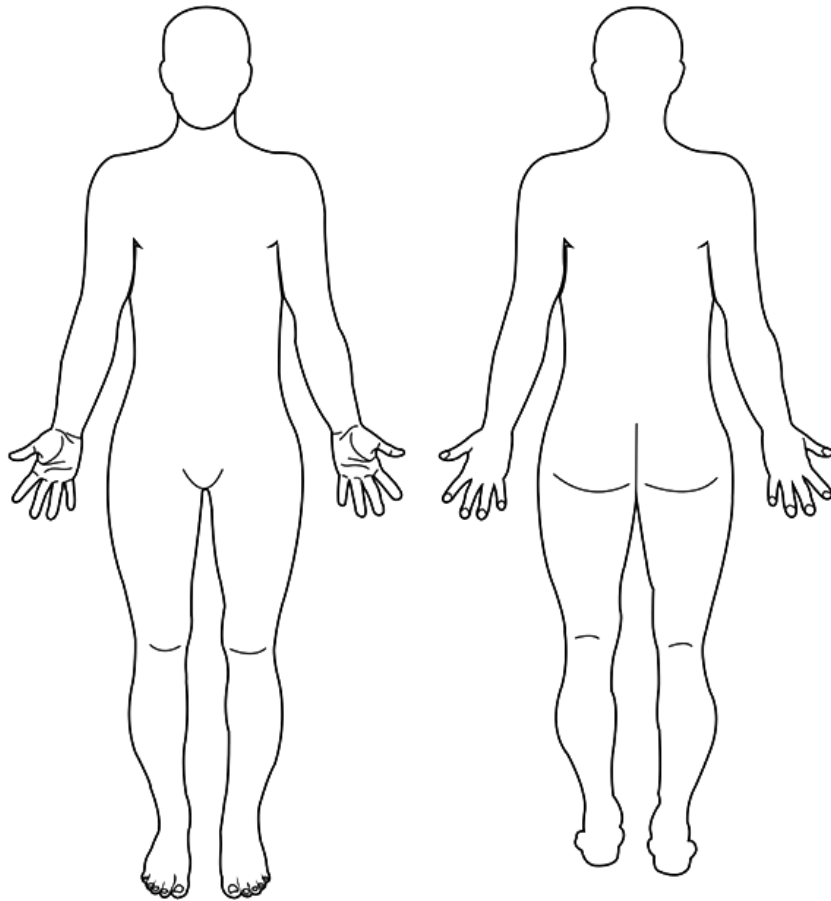
Recreational drugs (how often)? \_\_\_\_\_ Drink coffee (how often)? \_\_\_\_\_

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**

<b>Patient Name</b>		<b>Date of Birth</b>	
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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, bleeding, bruising, pneumothorax injury, organ puncture, nerve trauma, temporary discomfort, burns, 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 15 days to pay any invoiced fees, after which my credit card on file will be charged for any remaining balance if no payment is received. 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 48 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 48 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 15 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): \_\_\_\_\_