Ponderay Acupuncture Post Falls 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._____

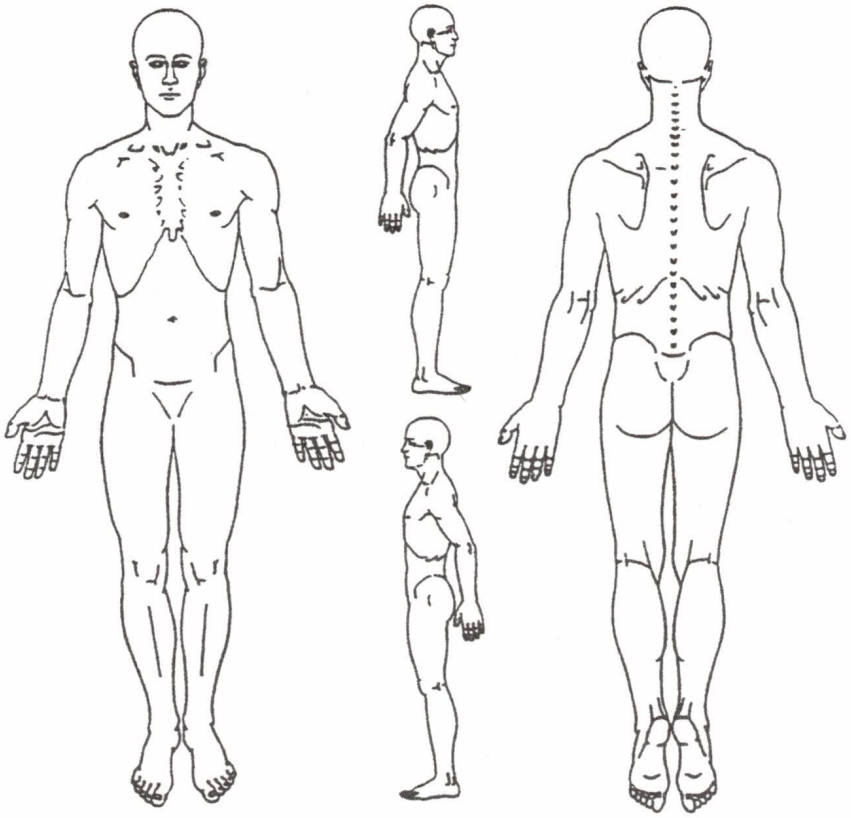
8._____

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 responsible for my healthcare decisions and that my acupuncturist will provide information to help me make informed choices about my care, including the purpose, benefits, potential risks, and alternatives to treatment. I voluntarily consent to receive acupuncture and other traditional East Asian medical treatments, which may include cupping, moxibustion, herbal medicine, massage techniques (Tui Na), nutritional guidance, or heat therapy.

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. Acupuncture is considered safe but may cause temporary side effects such as bruising, soreness, dizziness, or fainting. In rare cases, more serious complications such as infection, nerve irritation, or organ puncture may occur, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Cupping and moxibustion may leave marks, discomfort or burns. Herbs and supplements may have a strong taste or smell and could cause side effects such as digestive upset, rashes, or allergic reactions. Some herbs may be contraindicated during pregnancy or while breastfeeding, and I agree to inform my provider if I am pregnant, become pregnant, or 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.

I understand that acupuncture is not a substitute for Western medical care or diagnosis and that I should remain under the supervision of a primary care physician or appropriate medical specialist. I understand that no specific outcome is promised and that results may vary. I may ask questions at any time and may decline or stop treatment at my discretion. I understand that there are treatment options available for my condition other than acupuncture procedures. 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.

I understand that I am responsible for providing accurate and updated medical history, medications, allergies, and relevant information. My health records will be kept confidential and will not be released without my written permission. I understand that I have the right to seek a second opinion or explore other treatment options at any time.

TERMS AND CONDITIONS

I understand that there is a **24-hour policy** for cancellations and rescheduling, which must be done by phone. A **$55 fee** will be charged for late cancellations, late rescheduling, or missed appointments. It is my responsibility to remember my appointment date and time. Not receiving an electronic reminder is not a valid reason to miss an appointment. Emergency absences will be considered on a case-by-case basis. New Patients: A deposit is required to reserve a first-time appointment. If cancellation or rescheduling is necessary, 72 hours' notice is required. Failing to

provide 72 hours' notice may result in forfeiting the deposit. Late arrivals of 10 minutes or more will be considered a late cancellation and the cancellation fee may apply. Payment for treatment is due at the time of service. There are no refunds for herbal prescriptions or supplements. Refunds for acupuncture services are not guaranteed and will be considered on a case-by-case basis if requested by the patient.

PAYMENT AUTHORIZATION CONSENT

By signing below, I authorize Ponderay Acupuncture and Post Falls Acupuncture to securely store my credit or debit card information and charge it for services, products, and any outstanding balances related to my account. This includes charges for missed appointments or late cancellations in accordance with the clinic's policy, which may incur a $55 fee or forfeiture of a deposit. I understand this authorization will remain in effect until I notify the clinic in writing to revoke it. I also understand this card may be used to settle unpaid balances, including insurance adjustments not covered by my plan.

COMMUNICATION CONSENT & MESSAGE

I understand that my healthcare information is protected under HIPAA. I acknowledge that in some situations, a member of my household or a friend may answer the phone when the clinic contacts me, and I give permission for the office to ask for me by name in such cases.

By signing below, I consent to receive voicemails, text messages, and emails regarding appointment scheduling or changes, account balances or payments, cost estimates, treatment plans or updates, and information related to herbs or wellness. I understand that, under the HIPAA Privacy Rule, the clinic may use professional judgment to make certain disclosures in my best interest, even without this signature. I also understand that this consent applies only to verbal communications; no paper or electronic copies of my protected health information will be released without my signed authorization on a separate Release of Information form.

By voluntarily signing I show that I have read the entirety of the Acupuncture Informed Consent to Treat 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 or Signature of Representative Print Name Date

INSURANCE INFORMATION FORM

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

Primary Phone:_____Date Of Birth:_____

Mailing Address:_____

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

Patient Insurance Information

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

Primary Insurance Company:_____

Policy Holder's Name:_____Date of Birth:_____

Member ID #:_____Group #:_____

Secondary Insurance Company:_____

Policy Holder's Name:_____Date of Birth:_____

Member ID #:_____Group #:_____

I understand that all professional services provided by Nelson Ivan Comerci, L.Ac. are billed directly to me, the patient. While the clinic will submit insurance claims on my behalf as a courtesy, I acknowledge that I am ultimately responsible for all charges, regardless of insurance coverage. I understand that verification of insurance benefits is not a guarantee of payment. I am responsible for knowing the details of my insurance policy, including any deductibles, co-pays, co-insurance, out-of-network coverage, prior authorization requirements, or benefit limitations. I agree to pay any balance not covered by my insurance. I agree to notify the office of any changes in my insurance coverage. If my insurance is inactive or changes without notice, I accept full financial responsibility for any charges incurred.

I authorize Nelson Ivan Comerci, L.Ac. to release any medical information necessary to process my claims and secure payment for services provided. I authorize direct payment of medical benefits to Nelson Ivan Comerci, L.Ac., and authorize the release of my complete health record, covering all past, present, and future healthcare services, for the purpose of treatment, payment, or healthcare operations. This authorization will remain in effect until revoked in writing or until the death of the patient. I understand that I am the guarantor of this account (or the legal guardian of a minor/dependent) and accept full responsibility for any unpaid balances, including charges denied by insurance. I also understand that if this account is referred for legal or third-party collection, I will be responsible for all associated fees.
Please note: *This office does not bill Medicare or Medicaid.* By signing below, I confirm that I have read, understand, and agree to the terms of this financial and insurance policy.

_____

Signature of patient or authorized person Printed name Date