Rootstock
ACUPUNCTURE LLC

Client Information

Date of First Visit __ __/__ __/__ __
month day year

First Name	Gender	Date of Birth __ __/__ __/__ __ __ __ month day year
Last Name		Birth Place
Street Address City, State, ZIP	Occupation	
	Health Insurance Co:	
	Member ID #	
Phone ( ) - Alternate Phone ( ) - Is it ok to leave messages? ☐ Yes ☐ No Is it ok to text? ☐ Yes ☐ No	Email Address May we send you occasional updates and specials? ☐ Yes ☐ No	
Status (please circle): Single Partner Married Widowed Divorced		
Name of Emergency Contact Relationship	Phone ( ) - Alternate Phone ( ) -	
Name of your Primary Physician Name(s) of your Specialist Physician(s), if applicable. Please indicate specialty.		
Have you ever been treated with acupuncture before? ☐ Yes ☐ No Have you ever been treated with Chinese herbs before? ☐ Yes ☐ No		
How did you hear about Angela Kociolek, L.Ac. & Rootstock Acupuncture, LLC? Please circle all that apply: Google Facebook Schedulicity Print Referral Other _____ If referral, who may we thank?		
Your privacy is important. If we have a chance meeting in public, would you like Angela to acknowledge and greet you? ☐ Yes ☐ No		

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Policies

Planning for your Appointment
Eat lightly and please refrain from using any products with noticeable fragrance and avoid coffee or other stimulants prior to your appointment. Please make yourself comfortable in the waiting area. I will meet you there. Please plan to gently resume your day after your acupuncture session.

Payment
Full payment is due at the time of service unless we are filing insurance claims for you.

Clients who pay at time of service and who do not require additional filing and/or administrative assistance are eligible for the posted rates.

Cash or check are preferred. All major credit cards are accepted but are charged a small processing fee.

Returned checks will incur an additional fee commensurate with bank fees plus $10.

Insurance
We are currently participating providers with PacificSource Health Plans, Allegiance, Cigna and Blue Cross Blue Shield.

Sign here to authorize the above listed insurers to pay us directly: _____

You, the client, are responsible for understanding your insurance benefits, deductible, co-pays/co-insurance, etc. for acupuncture. You are responsible for full payment if your insurance company, for any reason, refuses coverage or sufficient payment for acupuncture services.

Appointment Times and Late Arrivals
Your appointment time is reserved for you and your needs. We make every possible effort to begin sessions at the scheduled time. Please be punctual for your appointment. If you will be more than five minutes late, please call or text (406)209-2570. Depending on the situation, we may need to reschedule.

Cancellations and Unattended Appointments
If you must cancel or reschedule, please provide no less than 25 hours notice so that another patient may have the opportunity to use your appointment slot. We understand this may not be possible in the case of an emergency. In this case, please notify us as soon as possible to reschedule. Unattended appointments or less than 25 hour notification will be charged $25 on the first occasion and full rate for any subsequent occasions.

Acknowledgement
I have read and understand the policies stated above.

Signature of Patient (or Guardian) _____

Date __ __/__ __/__ __
month day year

Thank you!

Acupuncture is Tax Deductible on your Federal Taxes: Keep track of your receipts or request a ledger at the end of the year. The cost of acupuncture and herbs *that are prescribed* are deductible medical expenses if the accumulated medical costs are over and above 7.5% of the patient adjusted gross income on the Federal 1040. (http://www.irs.gov/pub/irs-pdf/p502.pdf)

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Health Questionnaire

Today's Date __ __/__ __/__ __
month day year

First Name	Gender	Date of Birth __ __/__ __/__ __ __ __ month day year	
Last Name	Age	Height ‘ “	Weight lbs

Current State of Health

1. On the line below, please indicate your current state of health and type of care you are seeking now:
   [Acute pain or discomfort _____ Maintenance _____ Wellness & Preventative Care]

2. What is/are your primary health concern(s) _____

_____

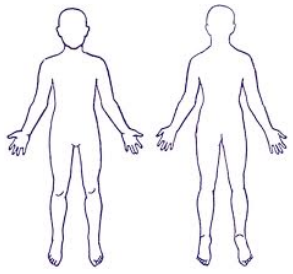
3. How long have you had the condition(s)?_____

4. How does it affect your daily activities in work, play or rest? _____

5. What makes it better or worse? _____

6. If you have any pain, please rate on a scale of 1 – 10 and mark all areas on the diagram.

Least 1 2 3 4 5 6 7 8 9 10 Most



Front Back

7. What other treatments/practitioners have you seen for this, if any? _____

Current Habits

1. Typical time you go to sleep: _____ a.m./p.m. Typical time you wake up: _____ a.m./p.m.

2. How many hours do you work per week? _____

3. How many ounces of water do you drink per day? ____ alcohol? ____ coffee? ____ soda? ____

4. Do you smoke cigarettes? ☐ Yes ☐ Have never smoked ☐ No longer smoke

5. Please check how often you do each of the following:	Multiple times a day	Daily	Every other day	Weekly	Less than weekly
Physical exercise					
Meditation					
Play, hobbies, joyful activities					

Medical History

1. Please list significant events you feel impacted your life or health. For example, births, deaths, marriage, divorce, accidents, major illness, surgery, job changes, miscarriages, trauma, anything else.

Age at time

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

2. Fill in if this applies to you: "I haven't felt like myself since…." _____

3. Please fill in your typical blood pressure reading: _____/ _____

4. Are you prone to fainting or seizures? ☐ Yes ☐ No

5. Do you have trouble feeling any parts of your body (numbness, etc.)? ☐ Yes ☐ No

6. Please list any known or suspected allergies, sensitivities or addictions to foods/drinks or medications:

_____

7. Please list any prescription or over-the-counter medications, vitamins, herbs, etc. you have taken within the last two months:

Item	Dose/ Frequency	Reason for Use	Still taking?

8. Check the illnesses in your family history: ☐ Cancer ☐ Heart disease ☐ Diabetes ☐ Arthritis ☐ Dementia ☐ Mental illness

Other? _____

For Females

1. Is it possible that you are pregnant now? ☐ Yes ☐ No If known, how many weeks? _____

2. When was the date of onset of your last menstrual cycle? __ __/__ __/__ __

3. Do you have concerns about your menstrual cycle or fertility? ☐ Yes ☐ No ☐ Maybe

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Informed Consent to Treatment

I, _____, hereby request and consent to treatments within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Angela Kociolek, a Licensed Acupuncturist (L.Ac.), owner of Rootstock Acupuncture, LLC.

I understand that the scope of acupuncture includes, but is not limited to, the insertion of solid, stainless steel needles through the skin; moxibustion or application of heat; cupping; electrical stimulation; Chinese herbs; and nutritional counseling. Acupuncture is intended to improve well-being by re-establishing harmonious function of body, mind, spirit and emotions, and by reducing pain or discomfort. Acupuncture works well in conjunction with Western medicine, chiropractic, osteopathy, and other healing methods.

I have been informed that acupuncture and associated treatments are generally safe and patients often report a decrease in symptoms and feelings of relaxation or improved energy, although some risks and side effects exist. Unusual risks of acupuncture include nerve damage, organ puncture (including pneumothorax), and infection - although sterile single-use needles and clean needle technique are used. Burns are a potential risk of moxibustion, heat lamps and cupping. Some possible side effects of acupuncture and associated treatments are brief minor pain, localized bruising or skin irritation, nausea, tingling, dizziness, fainting and temporary aggravation of pre-existing conditions.

I understand that “Chinese herbs” may include plant, animal and mineral products that are considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I will notify my practitioner if I prefer not to ingest particular product types or if I have known sensitivities to particular herbs or foods. I understand that herbal formulas should be prepared and consumed according to the instructions provided orally and in writing. Some possible side effects of taking herbal formulas are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, and tingling of the tongue.

I understand that some acupuncture points and herbs are contraindicated in pregnancy. I will inform my practitioner if I am or become pregnant to avoid the use of acupuncture points or herbs contraindicated in pregnancy. I do not expect my practitioner to anticipate all possible risks and complications. I wish to rely on professional judgment regarding my best interest based upon the facts known at the time. I understand that desired results are not guaranteed.

I have read the Notice of Privacy Practices and had an opportunity to ask questions about it. I understand that my medical records will not be released without my written consent (see Authorization to Release Medical Records). I have read, or have had read to me, the above which outlines potential benefits and risks of acupuncture and associated treatments, and have had an opportunity to ask questions. I voluntarily consent to treatment and intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature of Patient (or Guardian) _____Date __ __/__ __/__ __
month day year