laura ponce
ACUPUNCTURE & WELLNESS

Your Facts

A1

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Address: _____ **Apartment #:** _____

City: _____ **State:** _____ **Zip:** _____

Home #: _____ **Cell #:** _____

Email: _____

How did you find us? Patient *(who)*: _____ Doctor *(who)*: _____ Staff *(who)*: _____

(circle one) Promotion/Event Internet Newspaper Signage Business Insurance Other: _____

Date of Birth: ____/____/____ **Gender** (*circle one*): Male Female **Marital Status** (*circle one*): M D W S

Employer: _____ **Work #:** _____ **Ext:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone #:** _____

Primary Care Physician (PCP): _____ **Phone #** (PCP): _____

Are you currently taking any medications or supplements? (*Please include regularly used over the counter medications*).....

Medication Name	Dosage and Frequency

Supplement Name	Dosage and Frequency

Do you have any medication, food, or environment allergies?

Medication, Food or Location	Reaction

Please list 3 major health goals in order of priority:

(913) 962-7408 (office) | (913) 962-7416 (fax) | 7410 Switzer, Shawnee, KS 66203

Recreational Activities, Sports Played, Hobbies	
1. _____	☐ **past** ☐ **present**
2. _____	☐ **past** ☐ **present**
3. _____	☐ **past** ☐ **present**

A2

☐ **I do not want to know more about the benefits of becoming a Wellness Client.**

☐ **I choose to decline receipt of my clinical summary after every visit.** *(These are often blank as a result of the nature/frequency of chiropractic care)*

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I consent to the use or disclosure of my medical information by Laura Ponce, LLC and/or the affiliate practitioners that operate within Your Wellness Connection, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Laura Ponce, LLC. I understand that diagnosis or treatment of me by Laura Ponce, LLC may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my medical information is used or disclosed to carry out treatment, payment or health care operations of the practice. Laura Ponce, LLC is not required to agree to the restrictions that I may request. However, if Laura Ponce, LLC agrees to a restriction that I request, the restriction is binding on Laura Ponce, LLC. I have the right to revoke this consent, in writing, at any time, except to the extent Laura Ponce, LLC has taken action in reliance on this consent.

My "medical information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This medical information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand I have a right to review Laura Ponce, LLC's Notice of Privacy Practices prior to signing this document. A current copy is posted in the lobby of Your Wellness Connection.

The Notice of Privacy Practices describes the types of uses and disclosures of my medical information that will occur in my treatment, payment of my bills or in the performance of health care operations of Laura Ponce, LLC. This Notice of Privacy Practices also describes my rights and the duties of Laura Ponce, LLC with respect to my medical information. Laura Ponce, LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

*This includes the consent to consult with your current, past and future providers outside Laura Ponce, LLC about your care, conditions and treatment plans.

_____ **Today's Date:** ____/____/____

Patient or Personal Representative Signature:

_____

Printed Name of Patient or Personal Representative:

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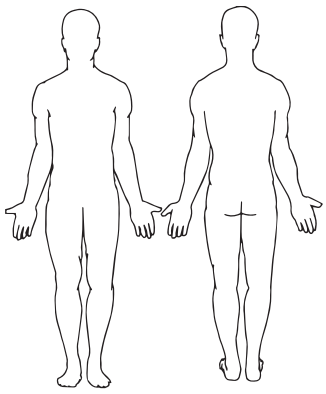
Your Consultation

A3

Name: _____ **Date of Birth:** _____ **Date:** _____

Pain Location



Front **Back**

Present Condition

List conditions in order of concern and mark location of pain.

(minor) **Pain Scale** *(extreme)*
1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

1. _____
2. _____
3. _____
4. _____
5. _____

Has condition changed since onset? ☐ Yes ☐ No ☐ Better ☐ Worse

Explain: _____

What makes pain better? _____

Worse? _____

Difficult activities: _____

Who Have You Seen:

Who have you seen for your symptoms, and when? ***Date***

Chiropractor: _____

_____

Medical Doctor: _____

_____

Physical Therapist: _____

_____

Other: _____

_____

Have You Had:

Blood analysis	☐ Yes	☐ No	_____ When
Blood pressure check	☐ Yes	☐ No	_____ When
Bone density	☐ Yes	☐ No	_____ When
Eye exam	☐ Yes	☐ No	_____ When
Feelings of hopelessness	☐ Yes	☐ No	_____ When
Feelings of depression	☐ Yes	☐ No	_____ When
Feelings of anxiety	☐ Yes	☐ No	_____ When
Feelings of panic	☐ Yes	☐ No	_____ When
MRI	☐ Yes	☐ No	_____ When
Spinal x-ray	☐ Yes	☐ No	_____ When

Current Symptoms

1
- ☐ Knee Pain
- ☐ Leg Cramps
- ☐ Numbness in Toes
- ☐ Tingling in Legs
- ☐ Weakness In Legs

2
- ☐ Urinating Issues
- ☐ Lower Back Pain
- ☐ Ringing in Ears

3
- ☐ Bladder Infections
- ☐ Belching
- ☐ Constipation

3
- ☐ Indigestion
- ☐ Vomiting

4
- ☐ Arm Pain
- ☐ Circulatory Problems
- ☐ Hands Cold
- ☐ Mid-Back Pain
- ☐ Numbness in Fingers
- ☐ Shortness of Breath
- ☐ Shoulder Pain
- ☐ Tingling in Arms

5
- ☐ Back Pain
- ☐ Dizziness
- ☐ Hair Loss
- ☐ Hay fever
- ☐ Hives
- ☐ Loss of Balance/Dizzy
- ☐ Neck Pain/Stiffness
- ☐ Nervousness

6
- ☐ Bruise Easily
- ☐ Diarrhea
- ☐ Feet Cold
- ☐ Frequent Colds
- ☐ Hemorrhoids

6
- ☐ Loss of Smell/Taste
- ☐ Muscle Spasms
- ☐ Sight Sensitivity
- ☐ Sinus Problems

7
- ☐ Cold/Hot Sweats
- ☐ Fatigue
- ☐ Fever
- ☐ Joints Swelling/Pain
- ☐ Sleep Problems
- ☐ Stress
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

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Your History

A4

Name: _____ **Date of Birth:** _____ **Date:** _____

Medical History

	Self	Siblings	Mom	Dad	GPs
ADD/ADHD	☐	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐
Arthritis - *Type*_____	☐	☐	☐	☐	☐
Birth Trauma	☐	☐	☐	☐	☐
Blood Pressure	☐	☐	☐	☐	☐
Cancer -*Type*_____	☐	☐	☐	☐	☐
Cholesterol - High	☐	☐	☐	☐	☐
Chronic Fatigue	☐	☐	☐	☐	☐
Colitis	☐	☐	☐	☐	☐
Convulsions	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Drug Addictions	☐	☐	☐	☐	☐
Eye Condition	☐	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐	☐	☐
Gall Bladder	☐	☐	☐	☐	☐
Gastric/Reflux/Ulcer	☐	☐	☐	☐	☐
Glasses/contacts	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Hemorrhoids	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐

	Self	Siblings	Mom	Dad	GPs
HIV/AIDS	☐	☐	☐	☐	☐
Immune System - Weak	☐	☐	☐	☐	☐
Irritable Bowel Syndrome	☐	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐	☐
Lupus	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	☐	☐
Muscular Dystrophy	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐
Rheumatic Fever	☐	☐	☐	☐	☐
Scarlet Fever	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Shingles	☐	☐	☐	☐	☐
Skin Disorder	☐	☐	☐	☐	☐
Sleep Disorder	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐
Varicose Veins	☐	☐	☐	☐	☐
Venereal Disease	☐	☐	☐	☐	☐
Weight Gain/Loss	☐	☐	☐	☐	☐
Other _____	☐	☐	☐	☐	☐
Other _____	☐	☐	☐	☐	☐
Other _____	☐	☐	☐	☐	☐

Patterns

Mark those that apply and amount if applicable.

Example: Lift Weights	**3 X wk**
Bowel movements	
Drive a stick shift	
Eat out frequently	
Enjoy work	
Exercise	
Healthy relationships	
Lift weights	
Nicotine	
Phone work excessive	
Skip meals	
Sleep comfortably	
Sleep on stomach	
Two story residence	
Wear seat belts	
Work hours per week	

Rate Your Activities

Rate the degree of pain related to performing these activities.

	None	Some	Always
Climbing Stairs	☐	☐	☐
Computer work	☐	☐	☐
Dressing	☐	☐	☐
Driving/riding in cars	☐	☐	☐
Exercise	☐	☐	☐
Getting in/out of cars	☐	☐	☐
Getting out of bed	☐	☐	☐
Using the restroom	☐	☐	☐
Housework	☐	☐	☐
Running	☐	☐	☐
Sexual Intercourse	☐	☐	☐
Sitting	☐	☐	☐
Taking care of child	☐	☐	☐
Walking	☐	☐	☐
Yard work	☐	☐	☐

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Your Life

A5

Name: _____ **Current Date:** _____ **Reassess Date:** _____

What is your story? *Take time to reflect on your life events from birth to the present time. What have your life events been? Start with birth moving through the life stages. Some examples are a difficult birth, accidents, marriage, divorce, deaths, starting a business, job changes, and financial issues.*

BIRTH TO 15 YEARS: _____

15 TO 30 YEARS: _____

30 TO 40 YEARS: _____

40 TO 50 YEARS: _____

50+ YEARS: _____

MY HYDRATION

What is your average daily intake? (oz.)

Water_____ Alcohol_____
Caffeine_____ Soft Drinks_____
Juice_____ Energy Drinks_____
Milk_____ Other *(write in)*_____

MY NUMBERS

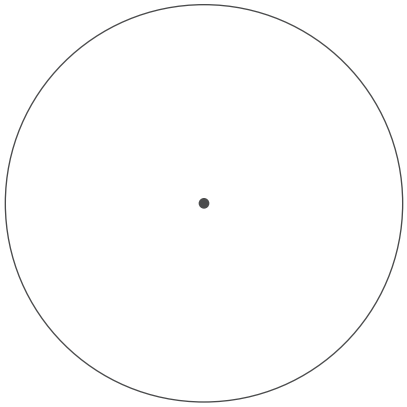
Please fill in the following...

Blood Pressure_____ Vitamin D Level_____
Blood Sugar_____ Height_____
Blood Type_____ Weight_____
Cholesterol_____ Other *(write in)* _____

MY FUEL

Think about how you eat in a typical week. Indicate what percent you eat of each of the following. (feel free to print this out and graph the chart)

- Processed Foods %_____
- Dairy %_____
- Animal Protein %_____
- Grains %_____
- Fruits %_____
- Vegetables %_____
- Good Fats %_____



MY WELLNESS PRACTICES

In the past 3 years, have you had...

- ☐ Blood analysis / lab work
- ☐ Blood pressure check
- ☐ Bone density scan
- ☐ Cardiovascular stress test
- ☐ Flexible sigmoidoscopy
- ☐ Hearing test
- ☐ Mammogram
- ☐ Pap/pelvic exam
- ☐ Prostate exam
- ☐ Spinal exam
- ☐ Dental exam

MY MEDICAL PRACTICES

Mark the wellness disciplines you use.

- ☐ Acupuncture
- ☐ Chiropractic
- ☐ Dental Care
- ☐ Exercise / Movement Classes
- ☐ Eye Care
- ☐ General Medical
- ☐ Massage Therapy
- ☐ Meditation / Prayer
- ☐ Nutritional Counseling
- ☐ Psychological Counseling
- ☐ Yoga

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Informed Consent

A6

Name: _____ **Date of Birth:** _____ **Date:** _____

Introduction: Please take a few minutes to carefully read the following and sign where indicated. If you have any questions about the information listed below, please ask the acupuncturist prior to signing this consent.

Guidelines: Please use the restroom prior to treatment. Avoid treatment when excessively fatigued, hungry, full, emotionally upset, if you have had alcohol, or shortly after sex. Focus on relaxing throughout the treatment. The more relaxed you are, the better your results will be. Some clients find it helpful to use deep breathing techniques. Do not change your position or move suddenly. If you are uncomfortable during your treatment, please call for your acupuncturist.

Risks: As with any medical procedure, there are risks involved. Your acupuncturist will take every precaution during the treatment to minimize any risks. Listed below is the information that is most important for you to understand prior to beginning your acupuncture treatment.

Needles: Your acupuncturist uses sterilized, individually packaged, disposable needles that are used once and then discarded. This eliminates the possibility of transmitting a communicable disease by a contaminated needle. The needles are typically inserted anywhere from ¼ to1 inch in depth, depending upon the client's size, age and constitution.

Bruising: You may note a spot of blood at one or more of the needle sites or a small bruise could develop. These are rarely harmful, but please talk to your acupuncturist if you are concerned.

Cupping: If cupping if used as a treatment, your acupuncturist will use different sized glass jars that are heated with a flame to attach to your back. Depending on one's physical condition, cupping can cause bruising, red marks and in some rare cases, blistering. All of these conditions will disappear without special treatment.

Herbals: Herbal medicine may be prescribed as a compliment to your acupuncture treatments and should be taken according to directions provided by the acupuncturist.

Symptoms: Symptoms Occasionally, a few people experience dizziness, nausea, cold sweats, and shortness of breath or lightheadedness during treatment. This often occurs if you are nervous. You should inform your practitioner immediately if you experience any discomfort, increased pain, or burning sensations.

Pain: If you find your treatment unbearable at any point, be sure to speak up so that your acupuncturist can make the proper adjustments or stop the treatment.

Treatment: Your acupuncturist will explain the nature of your problem and what treatment he or she is recommending. If you consent to go ahead with the recommended treatment, your acupuncturist will tell you what progress to expect, what to do if you do not experience that progress and what to do in the rare event that you feel worse.

Referrals: If you have been referred for acupuncture by one of our Doctors, your case will continue to be managed by your Doctor. Your Doctor, through consultations with your acupuncturist, will monitor your treatment plan.

Disclosure: I have read the above information and fully understand the risks involved in such treatment. I have been given the opportunity to ask any questions. All of my concerns have been addressed to my satisfaction. **I agree to fully disclose any symptoms and health problems of which I am aware throughout the treatment process and will update the acupuncturist immediately should my health status change in any manner.**

Signature: _____ **Today's Date:** ____/____/____

Printed Name: _____

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Financial Policy

A7.1

It is the policy of this office that all services rendered are the responsibility of the patient, and that you are ultimately personally responsible for all payments, regardless of whether or not this office accepts insurance assignment. All patients are responsible to check out with the front desk to satisfy any payment due at the time of the service.

1. Patients without Insurance:

All payments are expected at the time of service unless other arrangements are made with Laura Ponce, LLC. If an arrangement was made the payment for the service will be expected within 15 days of the service. If payment is not received within 15 days the balance due will be charged to the credit card listed on the credit card authorization that is listed at the end of this policy.

2. Patients with Insurance:

Deductibles, co-insurance and all co-payments, along with any services not covered by insurance are expected at the time of service. Unless other arrangement is made to delay this payment until the insurance company pays. Then the client will have 15 days to pay the balance due. If payment is not made in 15 days, the credit card listed on the credit card authorization that is listed at the end of this policy will be charged.

3. Purchase of Supplements, Supplies or Non Insurance Services:

All supplements, supplies and services not covered by insurance must be paid for at the time they are received. There are no exceptions on these items or services.

ASSIGNMENT OF BENEFITS: I, the undersigned, certify that I and/or my dependents have coverage with the insurance as presented to Laura Ponce, LLC and assign directly to Laura Ponce, LLC, all benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions. I acknowledge and understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information.

AUTHORIZATIONS: I hereby acknowledge that I have read the above policy regarding my financial responsibility to Laura Ponce, LLC for medical services and treatment provided and I agree to pay Laura Ponce, LLC any balance unpaid by my insurance carrier or not covered by an insurance carrier for myself and the person named below.

I hereby authorize Laura Ponce, LLC to charge my credit or debit card listed below for the full amount owed by me for all services and/or treatments, or supplements and supplies rendered by Laura Ponce, LLC in accordance with this agreement.

This authorization shall remain in effect unless and until it is revoked by you in writing and delivered to the office of Laura Ponce, LLC at 7410 Switzer Rd, Shawnee, KS 66203.

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS: I consent to the use or disclosure of my medical information by Laura Ponce, LLC and/or the affiliate practitioners that operate within Laura Ponce, LLC, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Laura Ponce, LLC. I understand that diagnosis or treatment of me by Laura Ponce, LLC may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my medical information is used or disclosed to carry out treatment, payment or health care operations of the practice. Laura Ponce, LLC is not required to agree to the restrictions that I may request. However, if Laura Ponce, LLC agrees to a restriction that I request, the restriction is binding on Laura Ponce, LLC. I have the right to revoke this consent, in writing, at any time, except to the extent Laura Ponce, LLC has taken action in reliance on this consent.

(Continued on next page...)

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Our Financial Policy *(continued...)*

A7.2

My "medical information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This medical information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand I have a right to review Laura Ponce, LLC's Notice of Privacy Practices prior to signing this document. A current copy is posted in the lobby of Your Wellness Connection.

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Patient Signature: _____ **Date:** _____

Printer Name: _____

Others covered by this agreement: _____

CREDIT CARD INFO

Credit Card # _____ **Card Type:** VISA MASTERCARD DISCOVER AMEX

Expiration Date: _____ **3-digit security code:** _____

Name as it appears on card: _____

Address statement is sent to: _____

_____

Authorization Signature: _____ **Date:** _____

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