



Tracy Saraduke, RN, M.Ac.
Licensed Acupuncturist, NCCAOM Certified, M.S., B.S.N.

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical benefits to which I am entitled, including private insurance and third party payors to Acupuncture in Evergreen (formerly TRACY MEDICAL ARTS, INC.) or Tracy Saraduke for any outstanding amount on account. A photocopy of this release is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment, and/or for medical treatment. I understand my records will not be released for 3rd party advertising.

Patient/Guardian _____ Date _____

FINANCIAL POLICY STATEMENT

Acupuncture in Evergreen (formerly TRACY MEDICAL ARTS, INC.) will provide a receipt accepted by insurance carriers for you to submit to their claims department. You are responsible for the entire bill when the services are rendered (PIP auto accident claims and Worker's Compensation claims are exceptions).

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to Acupuncture in Evergreen (formerly TRACY MEDICAL ARTS, INC.).

Although the above does not apply for those patients that are considered Worker's Compensation, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

I understand and agree that: if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Patient/Guardian/Responsible Party _____ Date _____

COLORADO MANDATORY DISCLOSURE STATEMENT

Tracy Saraduke, RN, B.S.N., Lic.Ac., M.Ac., M.S.
3082 Evergreen Parkway, Suite 2
Evergreen, CO 80439
Mailing address: 23720 Pondview Place, Golden, CO 80401

Phone: 303-670-9181
www.TracySaraduke.com

Education:

- Worsley Institute of Classical Acupuncture, Miami Lakes, Florida and The College of Traditional Acupuncture (United Kingdom), Licentiate in Acupuncture, (three-year program, 2,636 hours), 1996
- University of MD, College Park, MD, Masters of Science, 1991
- St. Louis University, St. Louis, MO, Bachelor of Science in Nursing, 1982
- Earlham College, Richmond, IN, Bachelor of Arts, 1979
- ToyoHari Association Seven-month Course (117 hours each time), 2001 and 2003
- Master of Acupuncture, Academy for Five Element Acupuncture, 2003

Credentials: National Board Certified Acupuncturist (NCCAOM), since 1996
Licensed Acupuncturist, State of Colorado, since 1996
Registered Nurse, State of Colorado

Memberships: Acupuncture Association of Colorado
ToyoHari Association, North America
American Association of Oriental Medicine

This acupuncturist complies with all the rules and regulations promulgated by the Department of Health, including those rules related to clean needle technique, the use of disposable needles, proper cleaning and sterilization of equipment, and the sanitizing of the acupuncture office.

Fee Schedule:

- Initial Consultation & Treatment: \$95, and extended acupuncture treatment: \$95.
- Routine Treatment: \$80, Moxa: \$25.00, Self SoTai: \$25, SoTai Ho or Rosen: \$75
- There may be additional treatment costs; these will be discussed before incurring.
- Cancellations without 24 hours notice may be billed a \$75.00 cancellation fee.

Patient Rights:

The patient is entitled to receive information about the methods of therapy, the techniques used and the duration of therapy, if known. The patient is entitled to seek a second opinion from another health care professional at any time. This acupuncturist has been trained in the recommendation and application of adjunct therapies and will refer the patient to these as appropriate. The patient is entitled to terminate therapy at any time. Sexual intimacy is never appropriate in a professional relationship and should be reported to the Division of Registration in the Department of Regulatory Agencies.

The practice of acupuncture in the State of Colorado is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions or complaints, contact the Acupuncturists Registration Office, 1560 Broadway, Suite 1340, Denver, CO 80202. Telephone (303) 894-7851.

I have read and understand this document.

Patient's or Guardian's Signature

Date

New Acupuncture Patient Intake Form

					Work Phone	
Patient last name	Patient First Name	M.I.	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Age	Date of Birth (MM/DD/YYYY) / /	
Insured ID or SSN	Insured Last Name	M.I.	First Name	Phone		
Patient Address		City	State	Zip		
Employer Name	Insurance Company	Group Plan # or Union Local				
Is illness or injury related to: <input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> Other	Do you have other insurance that might cover this illness/injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list other insurance company name:				
Please list your reason(s) for this visit or your condition(s) in order of importance: 1. _____ 2. _____ 3. _____ 4. _____	Date you first noticed: _____ _____ _____ _____	Using a scale in which "0" is <u>none</u> (no pain or symptoms) and "10" is <u>severe</u> pain or symptom(s), circle the number that best reflects your condition: ↓ none to severe ↓			Please check the box below that best represents how much of the time you feel pain or your symptom(s) for the listed reason:	
		0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%			
		0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%			
		0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%			

For each reason or condition listed above, please mark how it happened:

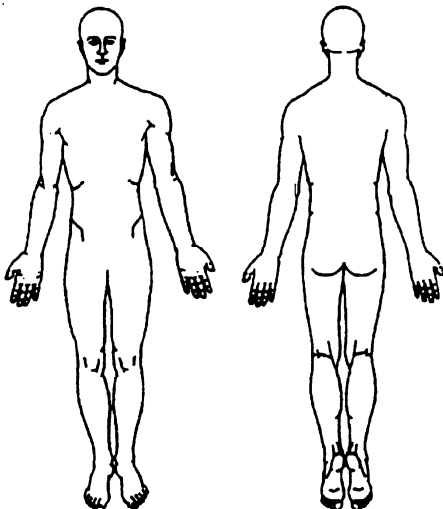
- Developed over time Illness Injury Auto accident Other _____ I don't know
- Developed over time Illness Injury Auto accident Other _____ I don't know
- Developed over time Illness Injury Auto accident Other _____ I don't know
- Developed over time Illness Injury Auto accident Other _____ I don't know

For each reason or condition listed above, please check if it is better or worse with any of the following:

	HEAT		COLD		REST		ACTIVITY		OTHER (please describe on line below)		
	<u>better</u>	<u>worse</u>	<u>better</u>	<u>worse</u>	<u>better</u>	<u>worse</u>	<u>better</u>	<u>worse</u>	<u>better</u>	<u>worse</u>	
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please mark the areas of discomfort or pain on the figures to the right using the symbol that best describes the feeling:

- +++ Sharp or stabbing
- ooo Pins and needles
- vvv Dull or aching
- /// Numbness



Please check the box that best describes whether your pain or symptom(s) limit normal activities:

Activity	normal	somewhat limited	severely limited
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resting in bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Computer work/typing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Normal work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Household activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreational activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (list below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient Name _____

- a. During what time of the day do you feel worse? _____
- b. Do you sleep well? Yes No What are your normal sleeping hours? _____ to _____
- c. Are you currently under the care of a medical doctor or other type of health care provider for any condition?
 No Yes → For what condition? _____

Name of doctor/provider _____ Phone number _____

- d. Please list any medications you are taking, the dosage, reason for taking and the date you started.
- | Medication | Dosage | Reason | Date started |
|------------|--------|--------|--------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

e. Please list any allergies _____

- f. Have you ever had an overnight stay in a hospital or a surgical procedure of any kind?
 No Yes If yes, please describe each event below:
- Event _____ Year _____
- Event _____ Year _____

- g. Please check the boxes that best describes your digestion: Good Indigestion Constipation
 Diarrhea Poor appetite Cravings (describe) _____

- h. Do you exercise? Yes No If yes, please describe activity _____
How many days a week? _____ How many minutes per session? _____

Questions i through k: FOR WOMEN ONLY

- i. Are you currently pregnant? Yes No Number of pregnancies? _____ Number of births? _____
- j. Are you nursing? Yes No
- k. **Menstrual history:** How many days from the start of your period until the start of your next period? _____
Date of last period? _____ How many days do your periods last? _____
How regular is your period? Regular Irregular
Please check the box that best describes your period: Scant, thin, red Heavy, dark, clotted Normal red flow
How do you feel before your period? Describe _____
How do you feel after your period? Describe _____

Personal history

The following lists a variety of conditions that patients may experience. Please read through the list and check the box next to each condition that applies to you.

Pain in body

- | | | |
|---|---|--|
| <input type="checkbox"/> Neck pain with difficulty swallowing | <input type="checkbox"/> Recent progressive muscle weakness or shaking | <input type="checkbox"/> Severe degenerative arthritis |
| <input type="checkbox"/> Extreme neck stiffness with pain or electric shocks in arms or legs when moving neck | <input type="checkbox"/> Recent or current fever over 102°F | <input type="checkbox"/> History of compression fracture |
| <input type="checkbox"/> Leg pain that worsens with exercise but is relieved by resting | <input type="checkbox"/> Loss of bowel or bladder control | <input type="checkbox"/> History of heart attack |
| <input type="checkbox"/> Loss of feeling in inner thighs | <input type="checkbox"/> Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions | <input type="checkbox"/> History of stroke or aneurysm |
| <input type="checkbox"/> Back pain with urinary problems | <input type="checkbox"/> Recent major accident such as a fall from height, whiplash or blow to the head | <input type="checkbox"/> Past history of cancer or currently diagnosed with cancer |
| Types of pain | <input type="checkbox"/> Memory loss after injury | <input type="checkbox"/> Diabetes with cold, burning or numb feet |
| <input type="checkbox"/> Severe pain interrupts sleep | Previously diagnosed condition/ medical history | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Constant pain that doesn't improve by changing positions or lying down | <input type="checkbox"/> Congenital bone or joint disorder | <input type="checkbox"/> Lupus |
| Current conditions | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Ankylosing spondylitis |
| <input type="checkbox"/> Unable to balance when walking | | <input type="checkbox"/> Immune suppression such as from chemotherapy, organ transplant, etc. |
| <input type="checkbox"/> Recent unexplained weight loss | | <input type="checkbox"/> 3 or more months use of steroid medications or intravenous drugs (past or recent) |

Family history

- | | | | |
|---|-----------------------------------|---|---|
| <input type="checkbox"/> Autoimmune disorders | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Seizure disorder |

I certify that the above information is true and correct to the best of my knowledge and I hereby consent to the release of my confidential medical and patient information in the possession of the Practitioner named above to other health professionals to whom I am referred and to the insurance company or other entity responsible for payment, utilization and/or quality review for all or a portion of my care.

Signature _____ Today's date: ____/____/____

If patient required assistance to complete, sign name and state relationship (i.e., parent, translator) below:

Name _____ Relationship _____ Today's date: ____/____/____

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