



<p>On a scale of 1-10, rate your commitment to get rid of the problem(s) and feel better _____</p> <p>Have you had acupuncture before? _____</p> <p>If yes, where/who _____</p> <p>Any concerns or fears about the needles? _____</p> <p>If yes, what? _____</p> <p>What are your goals of your acupuncture visits?</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p>	<p><b>MEDICAL CONDITIONS</b></p> <p>Please List conditions &amp; surgeries you have had and year diagnosed.</p>		<p><b>ALLERGIES</b></p> <p>Medications, Seasonal, Environmental, Food.</p>

**MEDICATIONS** – Please list all prescription medications you use. Include those which you may only use occasionally. Remember inhalers, eye drops and nose sprays. NOTE: If need more space, use page 4.

Prescription Name	Purpose	How Long	Dose	How Often	Last Dose

**SYMPTOMS** – **\*\*NOTE\*\*:** For each symptom you currently have, rate its severity from 1- 5 (5 being the worst). LEAVE BLANK IF NOT APPLICABLE.

<p><b>LIVER / GALLBLADDER</b></p> <p>_____ Irritability / Anger</p> <p>_____ Depression / Stress</p> <p>_____ Headaches / Migraines</p> <p>_____ Visual Problems</p> <p>_____ Red / Dry / Itchy Eyes</p> <p>_____ Gall Stones</p> <p>_____ Dizziness</p> <p>_____ Blurred Vision</p> <p>_____ Feeling of Lump in Throat</p> <p>_____ Clenching of Teeth at Night</p> <p>_____ Muscle Cramping / Twitching</p> <p>_____ Tension</p> <p>_____ Joints/Neck/Shoulder Pain/Tight</p> <p>_____ Poor Circulation</p> <p>_____ Soft / Brittle Nails</p> <p>_____ Emotional Eater</p> <p><b>KIDNEY / URINARY BLADDER</b></p> <p>_____ Urinary Problems</p> <p>_____ Bladder Infection</p> <p>_____ Lack of Bladder Control</p> <p>_____ Weakness / Pain in Lower Back</p> <p>_____ Decrease Bone Density</p> <p>_____ Feel Cold Easily</p> <p>_____ Low Sex Drive</p> <p>_____ Excess Sexual Desire</p> <p>_____ Poor Memory</p> <p>_____ Loss of Hair</p> <p>_____ Hearing Problems</p> <p>_____ Cavities</p> <p>_____ Craving / Avoiding Salty Foods</p> <p>_____ Fear</p> <p>_____ Hot Flush / Night Sweating</p>	<p><b>HEART / SMALL INTESTINES</b></p> <p>_____ Heart Palpitations</p> <p>_____ Chest Pain</p> <p>_____ Insomnia / Sleep Problems</p> <p>_____ Easily Startled</p> <p>_____ Restlessness / Agitation</p> <p>_____ Vivid Dreams</p> <p>_____ Lack of Joy in Life</p> <p><b>LUNG / LARGE INTESTINE</b></p> <p>_____ Dry Cough</p> <p>_____ Cough with Sputum</p> <p>_____ Nasal Discharge</p> <p>_____ Post-Nasal Drip</p> <p>_____ Sinus Infection / Congestion</p> <p>_____ Itchy, Red or Painful Throat</p> <p>_____ Dry Mouth / Throat / Nose</p> <p>_____ Skin Rashes / Hives</p> <p>_____ Snoring</p> <p>_____ Grief / Sadness</p> <p>_____ Shortness of Breath</p> <p>_____ Allergies / Asthma</p> <p>_____ Low Resistance to Colds or Flu</p> <p>_____ Sneezing</p> <p>_____ Mild Fever Comes &amp; Goes</p> <p>_____ Smoke Cigarettes</p>	<p><b>SPLEEN / STOMACH</b></p> <p>_____ Heaviness Anywhere in Body</p> <p>_____ Fatigue / Worse After Eating</p> <p>_____ Hard to Get Up in the Morning</p> <p>_____ Edema (Swelling)</p> <p>_____ Muscles Feel Tired Often</p> <p>_____ Easily Bruising &amp; Bleeding</p> <p>_____ Bad Breath</p> <p>_____ Decreased / Increased Appetite</p> <p>_____ Crave Sweets</p> <p>_____ Hypoglycemia</p> <p>_____ Difficulty Digesting Oily Foods</p> <p>_____ Nausea / Vomiting</p> <p>_____ Gas / Belching</p> <p>_____ Insulin Sensitivity</p> <p>_____ Hemorrhoids</p> <p>_____ Constipation</p> <p>_____ Diarrhea</p> <p>_____ Abdominal Pain</p> <p>_____ Indigestion / Heartburn</p> <p>_____ Over-Thinking</p> <p>_____ Tendency to Gain Weight</p> <p>_____ Brain Foggy</p>
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**PERSONAL MEDICAL & FAMILY HEALTH HISTORY**

Please indicate those that are current health problems for yourself and your family members with a “C” under the appropriate person’s column. “P” should be used to indicate a past problem. Leave blank those that do not apply. If you require more space, use the reverse side of this form.

	You	Father	Mother	Spouse	Brother(s)	Sister(s)	Children
<i>Age</i>							
AIDS / HIV							
Alcohol							
Anxiety							
Arthritis							
Asthma / Hay Fever / Allergy							
Back Trouble							
Bursitis							
Cancer							
Constipation							
Depression							
Diabetes							
Digestive Trouble							
Headaches							
Heart Trouble							
Hepatitis							
High Blood Pressure							
Immune Disorder							
Insomnia							
Kidney Trouble							
Liver Trouble							
Migraine							
Neck Pain							
Thyroid Disorder							
Tobacco							
Weight Problem							
Other Emotional Problems:							
Other:							

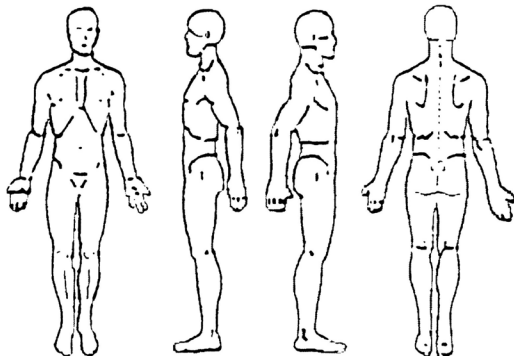
If any of the above family members are deceased, please list their age at death and cause.

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**MUSCULOSKELETAL**

- Muscle Cramps – Where?                       Muscle Pain / Rheumatism – Where?                       Arthritis – Where?
- Joint Swelling – Where?                       Tendonitis – Where?                       Bursitis – Where?

**Please mark problem areas on diagram:**



**Describe Pain and Location**

- Sharp     Burning     Aching
- Fixed     Other: \_\_\_\_\_
  
- Sharp     Burning     Aching
- Fixed     Other: \_\_\_\_\_
  
- Sharp     Burning     Aching
- Fixed     Other: \_\_\_\_\_

**Women Only**

Hysterectomy – Ovaries Removed?  Yes  No  
Could You be Pregnant Now?  Yes  No  
Number Of: \_\_\_\_\_ Pregnancies \_\_\_\_\_ Miscarriages  
                  \_\_\_\_\_ Births                    \_\_\_\_\_ Abortions

Post-menopausal Bleeding  Yes  No

When did your last period start? \_\_\_\_\_

Number of days for monthly cycle? \_\_\_\_\_

Number of days bleeding lasts? \_\_\_\_\_

Describe Menstrual Flow:

Heavy  Moderate  Light  None

Color of Menstrual Flow:

Dark  Bright Red  Slightly Reddish

Birth Control:

None  IUD  Birth Control Pills  
 Spermicides  Barriers

***Do You Suffer From:***

Cramping (*Mark as appropriate*)  
 Severe  Moderate  
 Mild  Before Period  
 During Period  After Period

Clotting (*Mark as appropriate*)  
 Bright in Color  Dark in Color

Bleeding Between Periods  Infertility  
 Pelvic Inflamm. Disease  Ovarian Cysts  
 Endometriosis  Hot Flashes  
 Mastitis  Breast Cysts

Yeast Infection / Vaginitis / Other Discharge

Premenstrual Syndrome (*Mark as appropriate*)  
 Fluid Retention  Cravings  
 Fluctuating Emotions  Irritability  
 Tenderness in Breasts  Depression  
 Fatigue

**Men Only**

Impotence  Weak Erection  
 Discharge from Penis  Prostate Problems  
 Testicular Pain or Lump  Infertility  
 Premature Ejaculation  Low Sex Drive

**Men and Women**

**Supplements**

Name	Purpose	How Long

**Diet**

What kinds (circle)	How much per day/week
Sugar: Candy	
Cookies / Baked goods	
Regular Soda / Diet Soda	
Chocolate	
Diary: Milk	
Cheese	
Yogurt	
Ice-cream	
White Flour: Bread	
Pasta	
Coffee	
Alcohol	
Protein 50g per day?	
Eggs	
Dark green/vegetables	
Fruits	
Eat Breakfast?	
Eat fast food / on the run?	

**Additional Notes**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Thank you for completing this form. Your time is greatly appreciated and we value this opportunity to serve you!**

**PROVIDER NOTICE OF PRIVACY PRACTICES**

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY. DEBRA KUHN GERSON, L.AC., DIPL. OM, FABORM, AND ALL OTHER HEALTH CARE PROVIDERS ARE REQUIRED TO INFORM YOU, THE PATIENT, HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. THE FOLLOWING ALSO OUTLINES HOW YOU CAN ACCESS YOUR HEALTH CARE INFORMATION.

PLEASE READ THE FOLLOWING CAREFULLY AND SIGN BELOW.

As your health care provider, I use your health information for evaluation, treatment, to obtain payment for treatment and to evaluate the quality of care that you receive. If you are referred to another health care provider, or at your request, your medical records may be shared with those providers via paper mail, electronic mail, fax or other methods.

We may use your health care information without your authorization for the following reasons:

1. Public health safety
2. Auditing purposes
3. Emergencies
4. At the request of your insurance carrier
5. When required by law

In all other circumstances, we will ask your written permission to release your medical information in the form of a "Release of Medical Records" form. If you choose to sign such a form, you have the right to revoke that authorization at any time.

If at any time we change our policies in regard to your medical information, you will be informed with a new "Notice of Privacy Practices" form and will be asked to sign it.

You have the right to view and obtain a copy of your medical record. You also have the right to know to whom we have disclosed your medical records. If you believe the information in your medical record is not correct or missing information, you have the right to request that such information is corrected or added to your medical record.

If you have any questions or concerns about your medical records, please contact Botanica Wellness Sanctuary, Inc. at 720-398-2050, or you can file a written complaint with the U.S. Department of Health and Human Services. Botanica Wellness Sanctuary, Inc. is required by law to protect your medical information and to provide this notice to you, along with your signature acknowledging your receipt of this information.

**AUTHORIZATION TO RELEASE INFORMATION**

I authorize Botanica Wellness Sanctuary, Inc. to release any information required to process this claim to any insurance company or attorney in this case. I also authorized any insurance company or medical provider to release my medical records to Integrative Health, Inc. This information is to be used for the purpose of processing my claim for benefits due. I hereby agree that a photocopy of the document is as valid and effective as the original copy.

**PAYMENT AGREEMENT**

I hereby authorize my insurance benefits to be paid directly to Botanica Wellness Sanctuary. I assume full responsibility for and agree to pay all costs, charges, and expenses of every kind and description for services furnished by Debra Kuhn Gerson, L.Ac., Dipl. OM, FABORM, Theresa Ugalde L. Ac., Dipl.OM, Janelle L.Ac, and all other health care providers. I must pay charges and services not covered by any insurance or other third-party payer and/or not paid to Botanica Wellness Sanctuary for any reason within a time period Botanica Wellness Sanctuary deems reasonable. The amount of the bill shall be due and payable upon presentation to the patient, his/her agent, guardian, conservator or third-party responsible for payment of the charges.

**CANCELLATION NOTICE**

Kindly give a 24 hour notice of cancellation. Late cancellations are subject to a 100% cancellation fee.

Patient's Name (Print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Debra Kuhn Gerson, L. Ac., Dipl. OM, FABORM  
Botanica Wellness Sanctuary  
1940 E 18<sup>th</sup> Ave. Denver, CO 80206  
Ph: (720) 398-2050

## **Colorado Mandatory Disclosure and Consent Form for Acupuncture**

Debra Kuhn Gerson, Theresa Ugalde L. Ac., Dipl.OM, and Janelle L.Ac have training and experience in the recommendation and application of adjunctive therapies and herbs as defined by Traditional Oriental Medicine. Acupuncture has been explained to me as a treatment consisting of the insertion of needles through the skin at specific points on the surface of the body, by well-trained, licensed acupuncturists. Acupressure, acupuncture, moxabustion, cupping, allergy elimination technique, nutritional or herbal counseling are considered experimental procedures and are not considered a substitute for Western Medicine. Therapies and advice offered shall not be construed by the client to be a diagnosis or treatment of any disease or injury.

I understand that complications may result from acupuncture treatment. Among these possible complications are areas of anesthesia, fainting, weakness, nausea, hematoma, infection, pain and discomfort, pneumothorax, and aggravation of present symptoms. Being hungry, tired, or stressed can infrequently make the body more sensitive to the acupuncture treatment. Please tell your provider if you have any conditions that may inhibit blood clotting, such as hemophilia, or coumadin use. Please use caution walking with bare feet in the treatment room. I, the patient, further understand and agree to hold harmless, indemnify and protect against court action the individual acupuncturist/therapist as well as the management and owners of this clinic, in the event of accidental injury on these premises.

We gladly accept auto claims, workman's comp, and insurance as payment. Insurance coverage depends on your plan. Please call head of time to find out what your acupuncture benefits are.

Our discounted time-of-service fee schedule is \$145 for Initial Acupuncture Session and \$89 for Follow-up Acupuncture Sessions.

Colorado law requires all acupuncturists provide the following information to clients on their first visit:

### Education, Experience, Degrees, Certificates, Credentials, Licenses, Certificates, and Registrations:

Debra Kuhn Gerson, L.Ac., Dipl. OM, FABORM, Theresa Ugalde L. Ac., Dipl.OM, and Janelle L.Ac have been licensed by the state of Colorado, which requires that they graduate from an approved institution (a four year program), and pass the National Board Exam (NCCAOM) for acupuncture and oriental medicine. Debra Kuhn Gerson, L.Ac., Dipl. OM, FABORM, Theresa Ugalde L. Ac., Dipl.OM, and Janelle L.Ac have never had any license, registration, or certification issued by any local, state or national healthcare agency, revoked or suspended.

This office complies with all rules and regulations promulgated by the Colorado Department of Health related to the proper cleaning and sterilization of needles used in the practice of acupuncture and the sanitation of acupuncture offices. This office uses only single-use disposable needles, and disposes of them in a manner consistent with OSHA and Colorado State regulations. We are trained in the recommendation and application of adjunctive therapies and herbs as defined by traditional Oriental medicine concepts

Each patient who visits this office is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.

In a professional relationship sexual intimacy is never appropriate and should be reported to the Director of the Divisions of Registrations in the Department of Regulatory Agencies: The Colorado Department of Regulatory Agencies regulates the practice of acupuncture. Send inquiries to the attention of: Director of the Professions and Occupations, Acupuncturist Licensure, 1560 Broadway, Suite 1350 Denver, CO 80202. Phone: (303) 894-7800 Email: dora\_acupunctureboard@state.co.us. Each patient may seek a second opinion from another healthcare professional or may terminate therapy at any time. If you have any questions about any part of your treatments, billing statements, etc., please ask the office manager and tell your provider.

I have read and understand the above disclosure statement. I understand my rights and responsibilities as a patient.

Patient's Name (Print): \_\_\_\_\_

\_\_\_\_\_  
**Signature of patient or legal guardian**

\_\_\_\_\_  
**Date Signed**

Debra Kuhn Gerson, L. Ac., Dipl. OM, FABORM  
Botanica Wellness Sanctuary  
1940 E 18<sup>th</sup> Ave. Denver, CO 80206

## BIOPUNCTURE INFORMED CONSENT

**Your treatment at Botanica may include biopuncture or B12 injections. For your convenience, please sign this form. Injections will never be performed without prior discussion with the practitioner.**

Whenever a needle is introduced through the skin, inherent risks are present. Although the risks are small, the expected benefit from the procedure must outweigh the possible risks. Make sure that you have a thorough understanding of the expected benefit from the injection. The risks of injection depend on where the injection is made and what is being injected. If the injection is made in a large muscle, the risk of hitting vital structures is very small. Injections in areas of neurovascular bundles (where nerves, veins, and arteries travel together) have a higher risk of injury, and injections in the area of the lung organs have a higher risk of injuring them.

The risks of injections are:

- 1) Infection: with current standard procedure of sterile needles and antiseptic technique, this risk is very small, but it still exists. Redness and swelling are early stages of infection. Any redness or swelling should be reported immediately to avoid more serious complications of sepsis (bacteria in the blood stream) or osteomyelitis (infection of the bone).
- 2) Puncture of the nerves, arteries, or veins: this risk varies greatly on the area of injection. When acupuncture point injections are made in the body of large muscles, this risk is very small. In other areas where the structures are larger and running together, the risk is increased. A nerve may be permanently damaged or bleeding may occur with puncture of a vein or artery.
- 3) Puncture of a lung or vital organ: injections in this area of the chest could puncture a lung in which the serious complication of a tension pneumothorax could occur. In this condition, the lung leaks air into the lung cavity progressively compressing the heart and lung. The person becomes short of breath, which can advance to death if untreated. Puncture of other vital organs is extremely unlikely and depends on the site of injection.
- 4) Allergic reaction the injected substance: allergic reactions to homeopathic substances have not been reported, and, in fact, they are used to treat allergic conditions. However, the possibility still exists. An allergic reaction is usually hives, but a lung reaction could occur with severe shortness of breath, or the most serious reaction of anaphylaxis. In anaphylaxis, there is an acute onset of shock, and this is a serious life-threatening emergency that could result in death.

### INFORMED CONSENT AND AGREEMENT

I, \_\_\_\_\_, hereby request and consent to injection therapy on my body, in order to enhance the effect of stimulating an acupuncture point. I understand that I will only be injected with substances that fall within the scope of Licensed Acupuncturists in Colorado. I understand the risks involved. I do not expect my practitioner to be able to anticipate all risks and complications. By signing this form, I agree to accept all the risks and release all liabilities from Debra Kuhn Gerson, L. Ac Dipl. OM and all other practitioners who may treat me.

Patient Signature (or Representative) \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_

Debra Kuhn Gerson, L. Ac., Dipl. OM, FABORM  
Botanica Wellness Sanctuary  
1940 E 18<sup>th</sup> Ave. Denver, CO 80206

# BOTANICA WELLNESS SANCTUARY

## CONSENT FOR PURPOSE OF TREATMENT & HEALTHCARE OPERATIONS

*In this document, "I" and "my" refer to the patient/client.*

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physiotherapy on me (or the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while working or associated with, or serving as a back-up for the acupuncturist named below, including those working at this or any other office, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping & gua sha, electrical stimulation, breathing techniques, exercise therapy Tui-Na (Chinese massage), Chinese or western herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. I understand that I should not make significant movements while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping and gua sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, mineral, and animal sources) that have been recommended are traditionally considered safe in the practice of Chinese medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue.

I understand that the herbs need to be consumed according to the instructions provided orally and in writing. I understand that some herbs may have an unpleasant taste or smell. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I will notify the acupuncturist who is caring for me if I am or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

**By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.**

\_\_\_\_\_  
Print Name of Patient  
X  
\_\_\_\_\_  
Signature of Patient (or Representative)

\_\_\_\_\_  
Print Name of Patient Representative  
X  
\_\_\_\_\_  
Date Consent Completed

\_\_\_\_\_  
Print Name of Acupuncturist  
X  
\_\_\_\_\_  
Signature of Acupuncturist

\_\_\_\_\_  
Print Name of Witness/Translator  
\_\_\_\_\_  
Signature of Witness/Translator



## Surprise/Balance Billing Disclosure Form

### Surprise Billing – Know Your Rights

Beginning January 1, 2020, Colorado state law protects you\* from “surprise billing,” also known as “balance billing.” These protections apply when:

- You receive covered emergency services, other than ambulance services, from an out-of-network provider in Colorado, and/or
- You unintentionally receive covered services from an out-of-network provider at an in-network facility in Colorado

### What is surprise/balance billing, and when does it happen?

If you are seen by a health care provider or use services in a facility or agency that is not in your health insurance plan’s provider network, sometimes referred to as “out-of-network,” you may receive a bill for additional costs associated with that care. Out-of-network health care providers often bill you for the difference between what your insurer decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called “surprise” or “balance” billing.

### When you CANNOT be balance-billed:

#### Emergency Services

If you are receiving emergency services, the most you can be billed for is your plan’s in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility where you receive emergency services and any providers that see you for emergency care.

#### Nonemergency Services at an In-Network or Out-of-Network Health Care Provider

The health care provider must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. They must also tell you what types of services that you will be using may be provided by any out-of-network provider.

**You have the right** to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. In this case, the most you can be billed for **covered** services is your in-network cost-sharing amount, which are copayments, deductibles, and/or coinsurance. These providers cannot balance bill you for additional costs.

### Additional Protections

- Your insurer will pay out-of-network providers and facilities directly.
- Your insurer must count any amount you pay for emergency services or certain out-of-network services (described above) toward your in-network deductible and out-of-pocket limit.
- Your provider, facility, hospital, or agency must refund any amount you overpay within sixty days of being notified.
- No one, including a provider, hospital, or insurer can ask you to limit or give up these rights.

***If you receive services from an out-of-network provider or facility or agency OTHER situation, you may still be balance billed, or you may be responsible for the entire bill. If you intentionally receive nonemergency services from an out-of-network provider or facility, you may also be balance billed.***

If you want to file a complaint against your health care provider, you can submit an online complaint by visiting this website: [https://www.colorado.gov/pacific/dora/DPO\\_File\\_Complaint](https://www.colorado.gov/pacific/dora/DPO_File_Complaint).

If you think you have received a bill for amounts other than your copayments, deductible, and/or coinsurance, please contact the billing department, or the Colorado Division of Insurance at 303-894-7490 or 1-800-930-3745.

\*This law does NOT apply to ALL Colorado health plans. It only applies if you have a “CO-DOI” on your health insurance ID card. Please contact your health insurance plan at the number on your health insurance ID card or the Colorado Division of Insurance with questions.

**Patient’s Name (Print) :** \_\_\_\_\_

**Patient’s Signature :** \_\_\_\_\_ **Date:** \_\_\_\_\_