Appointment Date:

General Information

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Married Single Partner Divorced Widowed Date of Birth _____ SS# _____

Work Phone _____ Home Phone _____ Mobile Phone _____

Email _____ Occupation _____

Emergency Contact _____ Referred By _____

Family Physician _____ Contact # _____

Have you had Acupuncture or Oriental medicine before? Yes No

Are your presently under a doctor's care? Yes No Who and for what? _____

Are there any other therapies which you are involved in? Who and for what? _____

Insurance Information

Insurance Company _____ Contact # _____

ID # _____ Co-pay $ _____ Visit # _____ Referral Yes No Covered % _____

Date called _____ Contact Name _____ Deductable amount _____

Focus

What is your primary reason for seeking care at our office? _____

What was the initial cause? _____

When did it begin? _____

What makes it worse? _____

What makes it better? _____

How does this problem interfere with your daily activities?

- ☐ Work
- ☐ Sleep
- ☐ Walking
- ☐ Sitting
- ☐ Standing
- ☐ Emotional
- ☐ Relationships
- ☐ Social Life
- ☐ Sexually
- ☐ Recreation
- ☐ Bending
- ☐ Stretching
- ☐ Other _____

What have you done about this? _____

Are you interested in:

- ☐ Pain Relief
- ☐ Preventative Care
- ☐ Oriental Nutrition
- ☐ Performance Care
- ☐ Holistic Health
- ☐ Meridian Yoga
- ☐ Maintenance Care
- ☐ Stress Relief
- ☐ Herbal Therapy
- ☐ Other _____

What are your health goals? _____

IRINA V. ZASIMOVA, M.D., PH.D.
LICENSED ACUPUNCTURIST

606 120TH AVE. NE, STE D – 202
BELLEVUE WA, 98005
425 455-8895

Financial Policies.

This is Financial Policy Agreement between **Irina V. Zasimova,** hereinafter referred to as "Practitioner", and undersigned, hereinafter referred to as "Patient". It is in the Practitioner's goal to have patients clearly understand their financial responsibilities before treatment begins. We desire to make your financial responsibilities as easy as possible and therefore, we offer the following financial arrangements.

1. **Patients with Insurance:** Estimated portion **not covered** by insurance is due at time of service. *(Please see " Insurance Section" below)
2. **Patients without Insurance:** Payment for services is due at the time of treatment.

The current rates:

First visit	$140.00	1 Hour
Individual body treatment	$90.00	1 Hour
Package of 10 treatments	$780.00	
Individual facial rejuvenation	$175.00	1½ Hours
Package of 12 treatments	$1450.00	
Following packages	$1350.00	
Kids under 12 years old	$75.00	
Seniors 65+	$75.00	
Package of 10 treatments	$650.00	

Herbs are varied in price and **not included** in the clinic fee.
The Practitioner will do what she can to accommodate those on a limited budget.

I HAVE READ AND UNDERSTOOD THESE POLICIES AND MY RESPONSIBILITY CONCERNING THE PAYMENT OF THESE SERVICES.

Patient signature_____**Date**_____

* Patients with Insurance:

- As a courtesy we bill your insurance carrier. However, it must be understood that the contract is between you and your insurance carrier, and you are fully responsible for any amount not paid.
- Our office does not guarantee that your insurance will pay. Some insurance companies do not cover acupuncture. We will assist you, if necessary, in making every attempt to receive verification of your policy. If, for any reason, your claim is denied, you are responsible for the full amount of your bill.
- Our office will not enter into a dispute with your insurance carrier over any unpaid claim.

Your signature below assigns permission to this office for collection of benefits and also authorizes this office to release daily chart notes when necessary for the processing of claims.

Patient signature_____**Date**_____

Office Polices.

- Please be on time for your appointment. Being late or last minute cancellation will cause severe scheduling disruptions, which can interfere with the quality of care you and other patients receive.
  Here is $75 fee for missed appointments and late cancellation (less then 3 hours prior your visit).
- Please do not wear strong perfumes or colognes. We see many patients with allergies or respiratory conditions, and strong scents can impair their progress.
- *If you need spend extra time discussing health concerns with the Practitioner, please let our staff know, so we may schedule your appointment accordingly*.
- Your health is our utmost concern. Please notify Practitioner of *any* changes in your health status, regardless of the significance.

Signature_____**Date**_____

If patient is under the age of 18 years old, the parent/guardian must read and sign the following:

As Parent/guardian of _____, I give permission for him/her to be treated **by Irina V. Zasimova** and will be responsible for any charges incurred.

Parent/Guardian_____**Date**_____

IRINA V. ZASIMOVA M.D., PH. D.
LICENSED ACUPUNCTURIST

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PATIENT CONSENT.

I_____ (full name) voluntary consent to be treated by Irina V. Zasimova, who offers several treatment modalities. The course of treatment will be determined between the health practitioner and me.
Irina Zasimova is licensed in the state of Washington to practice Acupuncture. She has a Master of Acupuncture and Oriental medicine degree from Seattle Institute of Oriental Medicine (2004). She is Diplomate in Acupuncture and Chinese Herbology. License # AC 2555 from Washington State Department of Health.
Doctor Zasimova's treatment consists of, but not limited to: Acupuncture, Electroacupuncture, Cupping, Moxa, Gua Sha, Plum Blossom, Dietary advices based on Traditional Chinese medical theory, and Herbal prescriptions.
Herbal prescriptions may include shell, minerals, and animal materials.
****If you do not want animal-based products used in your formula, please notify practitioner at every visit when herbs are prescribed.***

I acknowledge that there are some ***risks*** to the treatment. These ***side effects*** may include, but not limited to, the following: Discomfort and some pain following treatment in insertion area
Infection and blistering at the site of the procedure
Temporary discoloration of the skin
Broken needle
Nausea, loose bowel movement and abdominal cramping
Aggravating of symptoms existing before the treatment.

Patients with ***severe bleeding*** disorders or ***pace makers*** should inform the practitioner prior to any treatment. ***Pregnant*** patients or patients with a ***history of seizures*** should also inform the practitioner.

I understand that neither an implied nor a stated guarantee of success or effectiveness of a specific treatment or series of treatments. I understand that all my questions regarding the procedures will be answered, and that I am free to withdraw my consent and to discontinue treatment at any time.

I hereby release Irina V. Zasimova from any and all liability, which may occur in connection with the practiced procedures, except for failure to perform the procedures with appropriate medical care.

I hereby authorize Irina V. Zasimova to release any information regarding my condition to the referring physician (if any) and /or to my insurance for processing of any claim. With notification, I also authorize Irina Zasimova to obtain my medical records from other physicians or medical centers. The clinic will help me in preparing the necessary papers for my insurance.

I agree to give 24 hours notice to the clinic if I need to cancel or re-schedule an appointment. I understand that in case of unavoidable lateness by me or by the clinic, the schedule will be adjusted to provide me with treatment in its entirety.

I agree to pay in full amount at the conclusion of each appointment.

Herbal prescriptions vary in prices and are not included in the practitioner's fee.

I realize that I need to follow all instructions and recommendations given to me regarding my treatment.

PATIENT SIGNATURE_____ **DATE**_____