Impact Healing & Wellness Center
2121 S Oneida St (Suite 636)
Denver, CO 80224
(720) 588-5156
www.Impacthealing.com

Welcome to Impact Healing & Wellness Center!

Patient Information:

First Name: _____ Last Name: _____ Nick Name: _____

Date of Birth: _____/_____/_____ Age:_____ Preferred Gender: M F T

Address: _____City: _____ State: _____ Zip Code:_____

Cell: _____Home Phone: _____ Work:_____

Email: _____ Reminders: ❑ Text ❑ Phone ❑ Email

Occupation: _____ Employer: _____

Emergency Contact:

Name: _____ Phone: _____ Relationship: _____

Responsible Party (if not self):

Name of Responsible Party: _____

Date of Birth: _____/_____/_____

Phone: _____

Relationship: _____

Insurance Information:

Primary Insurance: _____

Member ID: _____

Group number:_____

Insurance Phone Number:_____

How did you hear about us?

- ❑ Family:_____
- ❑ Friend:_____
- ❑ Doctor:_____
- ❑ Insurance:_____
- ❑ Website
- ❑ Google search
- ❑ Triwest Healthcare Alliance
- ❑ Other:_____

Are you here visiting us to:

- ❑ Resolve my immediate Problem
- ❑ Lifestyle program for optimized living
- ❑ Both
- ❑ Other:_____

Are you here visiting us for:

- ❑ Pain
- ❑ Digestion: Reflux, Gas, Constipation
- ❑ Sleep: Falling asleep or staying asleep
- ❑ Energy
- ❑ Sense of Well Being

We appreciate you taking the time to fill out this information & Thank you for your visit!

The purpose of these pages are to allow us to more completely serve you and for you to get the best results in the shortest amount of time. It is our experience that treatment is most effective for patients who adhere to the following policies:

1. Clothing

   The acupuncture points for your condition will determine the areas of your body that need to be exposed. Please wear loose, comfortable clothing (e.g. pants that can be moved above the knee). If you need to change you may use our restroom facilities.

2. Payment

   We will expect you to honor your financial agreements you make with our office. If you find that you cannot fulfill the agreement you've made with us, please advise the office manager immediately so new agreements can be made. It is not our policy to bill patients (unless specific engagements have been made with the office manager at the start of treatment). Our policy is that patients not maintain a personal balance due.

3. Appointments

   Please arrive 5 minutes before your designated time. We have set up a specific course of treatment for you. A certain number of treatments in a set amount of time are required for us to get the results we both desire. Thus, we ask that you follow the guidelines below:

   - If you need to change the time of your appointment, plan to come another time on the same day.
   - If the same day is not possible, be sure to make up the missed appointment within 7 days.

   If you miss/cancel/reschedule your appointment without a 24-hour notice you will be charged $40 for each appointment due before your next treatment. ***Patient Initials:_____

4. Dietary Suggestions, Food Supplements, and Herbs

   If applicable dietary suggestions should be followed, herbs and food supplements taken, and liniments used. Any problems you may have with these recommendations should be communicated to your acupuncturist.

5. Sickness

   Infections and illnesses, such as colds, flu, ear infections, and allergies are often times easily treated if addressed within the first 24 hours of onset. If not immediately addressed, these conditions can cause two possible outcomes: first, it may prolong your movement to stabilization, and second, it could be complicated by your current herbal formula. It is essential to let your acupuncturist know of such illnesses.

6. Always Consult Your Doctor

   An acupuncturist in the State of Colorado is not licensed to prescribe pharmaceutical drugs. If you want the clinic to treat a condition that is currently medicated we will be happy to do so, so as long as the condition has been diagnosed by your doctor and is not an emergency condition. If the patient decides they want to alter their pharmaceutical regime in any way, the patient must consult their doctor before doing so.

7. Medical Release

   I authorize the release of medical information to my insurance company(ies), including diagnosis and the record of treatment or examinations rendered to me during the period of such medical care, and also request my insurance company(ies) to pay directly to Impact Healing for those medical services.

8. Consent to Email/Text for Reminders & Other Healthcare Communication

   Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

By signing you are agreeing that you have read and understood the policies above.

Signature of patient/ Guardian:_____Date:_____.

CO Mandatory Disclosure & Informed Consent

Sasha May earned her Master of Science in Traditional Chinese Medicine from the Colorado School of Traditional Chinese Medicine in May 2012. Michelle May earned her Master of Science in Traditional Chinese Medicine from the Colorado School of Traditional Chinese Medicine in Dec 2021. This three year program consists of 3,500 hours of education including 1,000 hours of clinical practice. Sasha and Michelle are both certified as a Diplomates in Oriental Medicine by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM# 151519-SM/ 849040-MM). This includes certification in Clean Needle Technique, Acupuncture, Asian Bodywork, and Chinese Herbology. Sasha and Michelle's training includes adjunctive therapies such as moxibustion, tui na, acupressure, cupping, auriculotherapy, and dietary and lifestyle recommendations. Both ladies are members of the Acupuncture Association of Colorado and are registered acupuncturists in Colorado. Neither license has ever been suspended or revoked.

FEE SCHEDULE

- ➢ Initial Consultation and Treatment: $185.00
- ➢ Follow up Treatments: $130.00

*services are provided on a cash basis; a superbill can be obtained upon request

INFORMED CONSENT

I hereby request and consent to the performance of acupuncture procedures by my acupuncturist, Sasha May. I have been informed that acupuncture is a safe method of treatment but that it may have side effects including discomfort, pain, dizziness, bruising, or numbness at the site of procedure. Unusual and rare risks of acupuncture include nerve damage, organ puncture including lung puncture, infection, and spontaneous miscarriage. Other side effects and risks may occur. If I suspect thatI am pregnant, I will immediately inform the acupuncturist.

I have discussed the nature and purpose of my treatment with the acupuncturist(s) named above. I understand that there are no guarantees regarding cure or improvement of my condition. I understand that there may be limitations to the care provided and that in my best interest I may be referred to another acupuncture practitioner or other healthcare provider who may be more qualified to treat me outside of these facilities. I do not expect the acupuncturist to anticipate and explain all possible risks and complications, and I permit the acupuncturist to determine and/or alter the course of treatment which the acupuncturist judges to be in my best interests based upon the facts then known. I understand that I have the choice to accept or reject treatment at any time. I have read the above consent. I have also had the opportunity to ask questions about its content, and by signing below, I agree to all terms and conditions stipulated by this document. I intend this form to cover the entire course of treatment for my condition and for any future condition(s) for which I seek treatment.

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 may seek a second opinion from another healthcare professional or may terminate at any time.
- In a professional relationship, sexual intimacy is never appropriate and should be reported to the Division of Registrations in the Department of Regulatory Agencies.

Impact Healing 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.The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Acupuncturists registration office at 1560 Broadway #1350, Denver, CO 80202. (303) 894-2440.

PROVIDER NOTICE OF PRIVACY PRACTICES

Impact Healing and all other health care providers are required by law to inform you, the patient, how medical information about you may be used and disclosed. As your Healthcare Provider, we use your health information for treatment, to obtain payment for treatment, for administrative purposes, 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, fax, or other methods. We may use our health care information without your authorization for the following reasons:

- Public Health Safety
- Auditing Purposes
- Emergencies
- At the request of your insurance car
- When required by law

Signature of Patient or Person authorized to consent:_____Date:_____

Health History Questionnaire

Name: _____ *Date:*_____

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment. All information is strictly confidential.

Major Complaint(s), in order of significance to you:

1._____ 3._____

2._____ 4._____

Medications you are currently taking:

Medication Name	Dosage	Medication Name	Dosage
1.		4.	
2.		5.	
3.		6.	

Supplements

1.		4.	
2.		5.	
3.		6.	

Do you have any Allergies?_____

Hospital Visits/Surgeries: _____(Procedure) _____ (Date of Surgery)

_____(Procedure) _____ (Date of Surgery)

_____(Procedure) _____ (Date of Surgery)

Name of your primary physician: _____

Is there anything limiting you from care? ❑ YES ❑ NO

_____

Is there anything else you wish to tell us?_____

office 720.588.5156 | fax 720.438.7928

IMPACT HEALING

Integrated Approach To Health

www.impacthealing.com | sasha@impacthealing.com

Name _____ Date _____

Please place a check for symptoms/diseases you have had in the past. Circle the name of any symptoms/diseases you currently are experiencing and write the frequency, intensity, and duration.

General Symptoms
- ☐ Tremors
- ☐ Headache
- ☐ Migraines
- ☐ Fever
- ☐ Chills
- ☐ Cold hands/feet
- ☐ Sweating
- ☐ Fainting/Dizziness/Vertigo
- ☐ Motion sickness
- ☐ Convulsions
- ☐ Loss of Sleep/Insomnia
- ☐ Fatigue
- ☐ Nervousness
- ☐ Depression
- ☐ Loss of Weight
- ☐ Forgetfulness
- ☐ Numbness or pain in arms, hands elbows, Shoulders, hips, legs, knees, feet
- ☐ Confusion
- ☐ Paralysis
- ☐ Other

Eyes, Ears, Nose, Throat
- ☐ Failing vision
- ☐ Eye pain or sensitivity
- ☐ Eye strain
- ☐ Blurry vision
- ☐ Cross eyed
- ☐ Eye inflammation
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Color blindness
- ☐ Spots/lines in vision
- ☐ Deafness
- ☐ Earache
- ☐ Loss of hearing
- ☐ Ear discharge
- ☐ Ear noises, ringing
- ☐ Nose bleeds
- ☐ Nasal obstruction
- ☐ Nasal drainage
- ☐ Loss of smell
- ☐ Sinus infection
- ☐ Hay fever
- ☐ Allergies
- ☐ Sore throat
- ☐ hoarseness
- ☐ Difficult Speech
- ☐ Difficult swallowing
- ☐ Loss of taste or change in tastes
- ☐ Dental decay
- ☐ Gum problems
- ☐ Tonsillitis
- ☐ Asthma / Bronchitis / Pneumonia
- ☐ Frequent colds / flu
- ☐ Thyroid problems
- ☐ Enlarged / swelling glands
- ☐ Other

Skin, Hair, Nails
- ☐ Skin eruptions
- ☐ Eczema /Psoriasis
- ☐ Itching
- ☐ Clammy skin
- ☐ Dryness
- ☐ Bruise easily
- ☐ Cuts heal slowly
- ☐ Boils
- ☐ Rashes
- ☐ Moles / Warts
- ☐ Sensitive skin
- ☐ Hives or allergy
- ☐ Hair problems
- ☐ Finger / Toenail problems

Respiratory
- ☐ Chronic cough
- ☐ Spitting up phlegm
- ☐ Spitting up blood
- ☐ Chest pain
- ☐ Difficulty breathing
- ☐ Wheezing
- ☐ Other

Cario-vascular
- ☐ Rapid beating heart
- ☐ Slow beating heart
- ☐ Irregular beating heart
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pain over heart
- ☐ Previous stroke
- ☐ Hardening of arteries
- ☐ Swelling of ankles
- ☐ Poor circulation
- ☐ Paralytic stroke
- ☐ Varicose veins
- ☐ High Cholesterol
- ☐ Low Cholesterol
- ☐ Anemia
- ☐ Other

Muscle & Joints
- ☐ Stiff neck or neck pain
- ☐ Pain between shoulders
- ☐ Backache
- ☐ Painful tailbone Foot, toes, heel problems
- ☐ Hand, wrist or finger problems
- ☐ Hernia
- ☐ Spinal curvature
- ☐ Faulty posture
- ☐ Swollen joints
- ☐ Stiff joints
- ☐ Painful joints
- ☐ Arthritis
- ☐ Sore muscles
- ☐ Weak muscles
- ☐ Walking problems
- ☐ Sciatica

Other

Genitourinary
- ☐ Frequent urination
- ☐ Scanty urine
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Pus in urine
- ☐ Kidney infection or stones
- ☐ Bed wetting
- ☐ Inability to control urine
- ☐ Bladder problems
- ☐ Foul smelling urine
- ☐ Discolored / cloudy urine
- ☐ Urinary tract infections
- ☐ Other

Gastrointestinal
- ☐ Eating disorder
- ☐ Poor appetitie
- ☐ Excessive hunger
- ☐ Difficult chewing
- ☐ Belching
- ☐ Bad breath
- ☐ Nausea
- ☐ Gas
- ☐ Indigestion
- ☐ Heartburn
- ☐ Vomiting
- ☐ Vomiting of blood
- ☐ Pain in abdominal area
- ☐ Distention of abdomen / Bloating
- ☐ Constipation
- ☐ Diarrhea
- ☐ Undigested food in stool
- ☐ Black stool
- ☐ Blood in stool
- ☐ Mucous in stool
- ☐ Colon problems
- ☐ Anal problems
- ☐ Hemorrhoids (Piles)
- ☐ Intestinal worms
- ☐ Liver problems
- ☐ Gall bladder problems / stones
- ☐ Jaundice
- ☐ Colitis
- ☐ Weight problems
- ☐ Other

Female
- ☐ PMS
- ☐ Painful menstrual periods
- ☐ Excessive flow
- ☐ Hot flashes
- ☐ Irregular cycle
- ☐ Period ramps or backache
- ☐ Previous miscarriage
- ☐ Vaginal discharge
- ☐ Vaginal pain
- ☐ Breast pain
- ☐ Lumps in breast
- ☐ Menopausal symptoms
- ☐ Abnormal bleeding
- ☐ Reduced sex drive
- ☐ Pregnancy
- ☐ Pregnancy complications
- ☐ Abnormal Pap tests
- ☐ Other

Male
- ☐ Prostate problems
- ☐ Genital pain or problems
- ☐ Reduced sex drive
- ☐ Premature ejaculation
- ☐ Seminal emission
- ☐ Impotence
- ☐ Discharges
- ☐ Other

Other
- ☐ Edema Hepatitis
- ☐ Herpes
- ☐ Cancer
- ☐ Diabetes
- ☐ TB Epilepsy
- ☐ Alcoholism / Substance abuse
- ☐ Depression
- ☐ Mental / Emotional disorder
- ☐ HIV+ / AIDS
- ☐ Vereal disease
- ☐ Other

Fee Schedule

New Patient Evaluation (Consultation & First Treatment). . . $185

This visit Includes the initial consultation, examination, and first acupuncture treatment.

Single Treatment/Follow-up (Acupuncture Treatment). . . $130

*****Herbs are sold and purchased separately*****

2023 Acupuncture Packages:

New Patient Program *(Only available for new patients during time of first visit*)*

Treatment Package Description:	4 Treatments
Total Amount:	**$480**

Corrective Care Program:

Treatment Package Description:	8 Treatments
Total Amount:	**$920**

Maintenance Program:

Treatment Package Description:	12 treatments
Total Amount:	**$1,320**

All program treatments expire 12 months after date of purchase

Military Discount: 20% off acupuncture Services!

VIP Wellness Package: [Only available to graduated program members]

Treatment Package Description:	12 Acupuncture Treatments 2 Supplement Reviews w/Sasha 5% off supplements Scheduling Priority
Total Amount:	**$1,495**
