Directions

Sandra Broberg

Body in Balance Acupuncture

4500 9th Ave. NE, Suite 300, Seattle, WA 98105
206-841-8500

Body in Balance Acupuncture PLLC is located in the University District, on 45th Street, just one block west of Roosevelt Avenue. From I-5 north or south, take the 45th Street exit and head east on 45th. Take a left on 9th Avenue NE (in front of the movie theater). Take a right on 47th and then the first right into the parking lot. My office is located in the University Business Center, on the third floor of the AMC Seattle movie theater. You can enter via an elevator located next to the theater entrance. Once on the third floor, go past the reception desk to the end of the hall and take a left. My office is in the first hallway on the right. Ring the bell when you get to my office.

For patients arriving before 8:30, after 5:30, or on weekends, the building or the security gate may be locked. If this occurs, please call 206-841-8500 (this is a landline and does not accept text messages) to let me know you're here, and I'll let you in. If I don't answer, leave a voicemail. I'm likely in with a patient and will come and get you as soon as I am able.

Parking: The easiest option is to take advantage of free two-hour street parking. Otherwise, there is free one-hour validated parking in spots #1-157 in the lot to the north of the building (the open lot and the 2nd and 3rd floor of the parking garage). The parking area is accessed from 47th Street, at the corner of 9th and 47th. (The lower level is for Trader Joe's parking only.) The lot across the street is pay-parking only, except for visitors with a disabled parking privilege plate or placard, who can park free in any of the handicapped stalls.

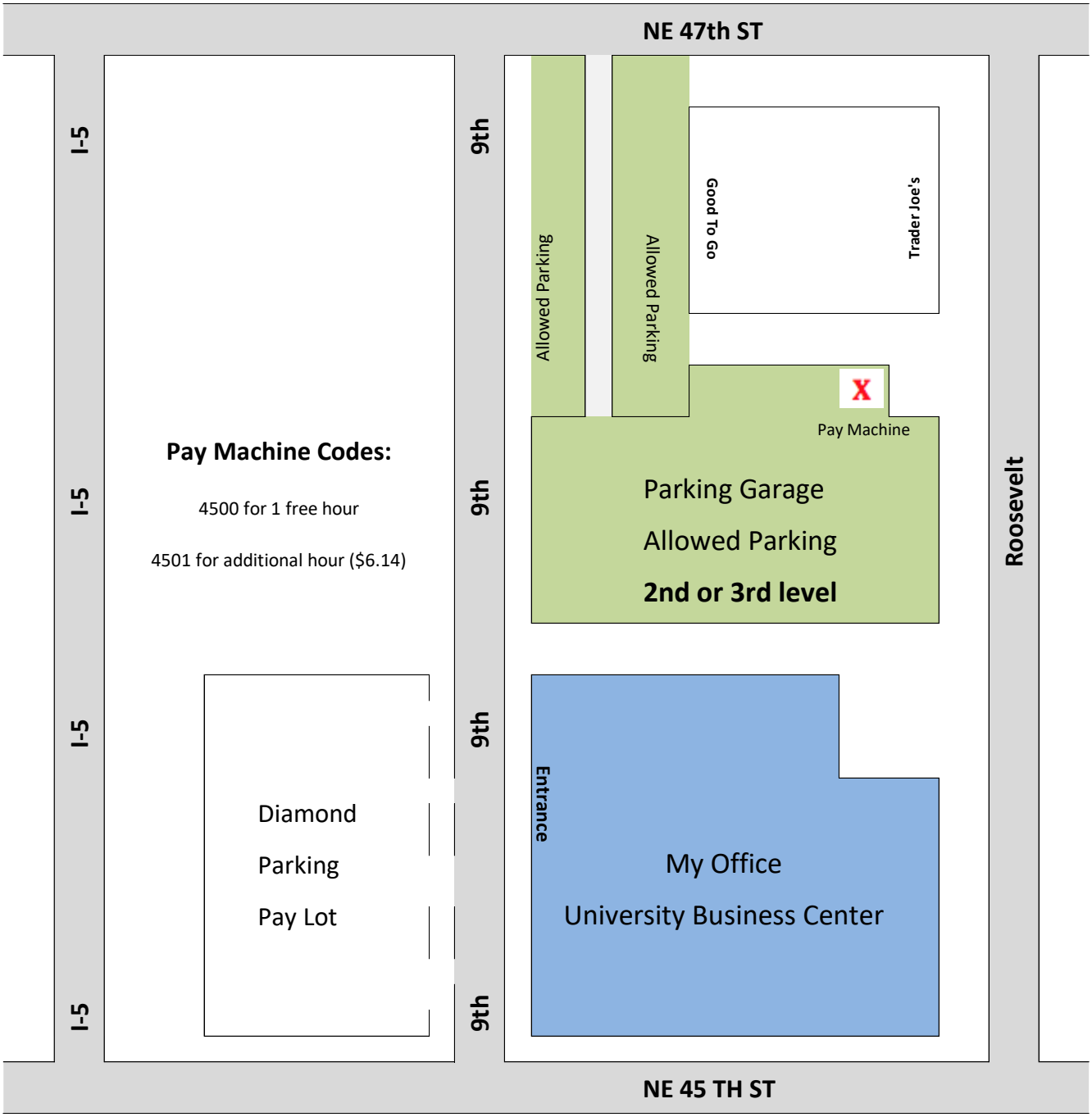
To register for one hour of free parking:

- Park in one of the available spots.
- Go to the pay station in the parking garage (located by stall #73 in the northeast corner)
- Press any button to turn on the machine. Enter your license plate number and press OK.
- Select Option "5) More Selections…"
- On the second screen, select Option "1) Biz Ctr – 1 hour free"
- Enter validation number (4500).
- Remove receipt from machine and put it on your dash

For one additional hour of parking (may be free or may have to pay):

- Activate the machine again. Enter your stall number and press OK
- Select Option "5) More Selections…"
- On the second screen select Option "2) – Biz Ctr - Plus 2nd HR"
- Enter validation number (4501 is the policy, but may be free if you enter 4500 instead)
- Make payment if required.
- Remove receipt from machine and put it on your dash

One Hour of Free Parking for Body in Balance Acupuncture



Sandra Broberg
Body in Balance Acupuncture PLLC

Welcome to Body in Balance Acupuncture! I look forward to working with you. I want to reassure you that acupuncture is safe and, by and large, painless. Most people experience an overall sense of relaxation and well-being. To help serve you better, I've listed some guidelines and office policies.

Appointments and Fee Information:

Your initial visit will last approximately one hour; return visits are usually about 40 minutes to one hour.

My fees vary depending on the number of modalities used during a treatment and on the complexity of the case. I do offer a discount if you pay at the time of treatment and we do not bill. This discount does not apply with other discount offers. You are responsible for all fees. If insurance is covering the cost of the treatment, you are responsible for paying the co-payment at the time services are rendered.

Other Recommendations:

- As many of my patients have chemical sensitivities, please refrain from wearing scented lotions, perfumes, and colognes to your treatment.
- Please do not come on an empty stomach, but it's also best not to eat a big meal directly prior to your treatment.
- It is okay to work out after your appointment, but I recommend not engaging in vigorous physical activity within an hour directly before or after the treatment.
- Do not come in to your appointment if you have COVID or COVID symptoms (a fever, a new cough, difficulty breathing [aside from a prior history of asthma or allergies], or an acute loss of your sense of smell) or are ill.
- I ask that you wear a mask if you have sneezing or a cough or have been in recent contact with anyone who's had COVID, COVID symptoms, or the flu.

Client Acknowledgement:

I understand the contents of this disclosure and agree to abide by these policies. I understand that I am financially responsible for all charges and agree to pay for services. I authorize Sandra Broberg to release to my insurance company or companies all and any information necessary to process any claim. I further authorize that payment(s) be made directly to Sandra Broberg.

_____ _____

Client Date

I am pleased to have you as a patient and hope you will soon share my enthusiasm for the health-enhancing benefits of acupuncture. My goal is to support your body's natural healing process and to assist you in improving your overall health and vitality.

CONSENT FORM
Patient Notification of Qualifications and Scope of Practice

Acupuncture and Eastern medicine means a health care service using acupuncture and Eastern medicine diagnosis and treatment to promote health and treat organic or functional disorders.

1. My qualifications include the following education and license information:
   License: Washington AC 00000477
   Education: Masters in Acupuncture, NIAOM, 1998
   Masters in Chinese Herbology, 2000

2. The scope of practice for an acupuncture and Eastern medicine practitioner in the state of Washington includes the following:

   (a) Acupuncture, including the use of acupuncture needles or lancets to directly or indirectly stimulate acupuncture points and meridians;
   (b) Use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians;
   (c) Moxibustion – application of heat to points;
   (d) Acupressure;
   (e) Cupping – creating a vacuum over the skin;
   (f) Dermal friction technique – rubbing an area of the body with a blunt, round instrument;
   (g) Infra-red;
   (h) Sonopuncture;
   (i) Laserpuncture;
   (j) Point injection therapy (aquapuncture); and
   (k) Dietary advice and health education based on East Asian medical theory, including the recommendation and sale of herbs, vitamins, minerals, and dietary and nutritional supplements;
   (l) Breathing, relaxation, and East Asian exercise techniques;
   (m) Qi gong;
   (n) Eastern massage and Tui na, which is a method of Eastern bodywork, characterized by the kneading, pressing, rolling, shaking, and stretching of the body and does not include spinal manipulation; and
   (o) Superficial heat and cold therapies.

3. Side effects may include, but are not limited to: Pain following treatment; minor bruising; infection; needle sickness; and broken needle.

4. The patient must inform the acupuncturist if the patient has a severe bleeding disorder or pace maker prior to any treatment.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Sandra Broberg regarding cure or improvement of my condition.

I hereby release Sandra Broberg from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and to discontinue participation in these procedures.

Signature of Patient Date

Signature of Person Authorized to Consent Date

Body in Balance Acupuncture PLLC
4500 9th Ave NE, Suite 300
Seattle, WA 98105
Phone: (206) 841-8500
Fax: (206) 629-6409

Cancellation Policy

(Updated 10-1-2024)

If you are unable to keep your appointment, I ask that you contact my office at least 24 hours in advance to cancel or reschedule the appointment. Otherwise, you will be charged $50 for the appointment. If there are more than two missed appointments in a calendar year, then the rate charged for subsequent missed appointments will be $100.

This cancellation fee will be waived in cases of emergency, illness, or the need to quarantine as long as you notify my office in advance.

Please sign to confirm that you understand and agree to abide by this cancellation policy.

Signature_____ Date_____

Print Name_____

Body In Balance AcupuncturePLLC
Sandra Broberg, L.A.C.
4500 9th Ave NE, Suite 300
Seattle, WA 98105
Phone: (206) 841-8500

NOTICE: PATIENT PRIVACY **Date: February 15, 2014**

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

We are required by law to have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, complaining if you think your rights have been violated, and being notified if there is a breach of your unsecured medical information.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our Notice from time to time. The effective date at the top right hand side of this page indicates the date of the most current Notice in effect.

You have the right to receive a copy of our most current Notice in effect. If you have not yet reserved a copy of our current Notice, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the Notice or your medical information, please contact **Sandra Broberg** of our office at **(206) 841-8500**.

PATIENT SIGNATURE: _____ **DATE:** _____

Body in Balance Acupuncture PLLC
4500 9th Ave NE, Suite 300
Seattle, WA 98105
Phone: (206) 841-8500
Fax: (206) 629-6409

Billing Information

You only need to complete the relevant section: pay out of pocket; personal health insurance; personal injury protection (PIP) [if auto accident], or third party pay (lein) [if auto accident and no PIP insurance].

PERSONAL HEALTH INSURANCE INFORMATION (IF APPLICABLE)

(If you don't have personal health insurance that covers acupuncture and the main complaint is not a result of an auto accident occurring in the last 3 years, complete the bottom section.)

Please provide your driver's license and current insurance card to the office staff.

Your Name_____ Date of Birth_____

Name of Insurance Company_____ Insurance Phone_____

Policy or ID No._____ Group No._____

Name of Policy Holder_____ Your Relationship to Holder_____

Insurance Limitation, if any: Yearly Visits_____

Monetary_____

Deductible_____ Co-Pay_____ per visit Coinsurance_____

Other_____

CHECKING YOUR INSURANCE COVERAGE IS A COURTESY WE OFTEN PROVIDE; HOWEVER, IT IS YOUR RESPONSIBILITY TO CONFIRM YOUR COVERAGE WITH YOUR INSURANCE COMPANY.

- My signature below authorizes the release of any medical or other information acquired concerning my condition or other disabilities, both to and from this acupuncturist, which will assist in the payment of any claim now or in the future. I agree to notify you if there is any change regarding this.
- My signature below authorizes my insurance company to send payments directly to Body in Balance Acupuncture PLLC for services rendered to me.
- I understand I am financially responsible for any balance not covered by my insurance carrier.
- My signature below authorizes the provider to send bills directly to my insurance company. I agree to pay the remaining balance within 30 days of receiving an itemized statement. I understand that any delinquent bills sent to collections will incur a 30% additional charge.

Signature_____ Date_____

OR CASH BASIS: I choose to pay for acupuncture services out of pocket. I understand that Sandra will not be billing any insurance company for the services rendered.

Signature_____ Date_____

Body in Balance Acupuncture PLLC
4500 9th Ave NE, Suite 300
Seattle, WA 98105
Phone: (206) 841-8500
Fax: (206) 629-6409

Billing Information if Auto Accident

(ONLY COMPLETE THIS PAGE IF APPLICABLE)

AUTOMOBILE/PERSONAL INJURY PROTECTION (PIP) INSURANCE INFORMATION (IF APPLICABLE)

Your Name_____ Date of Injury_____
My Automobile Insurance Company_____ Policy Holder_____
Insurance Co.'s Address_____
Insurance Company's Phone No._____ Adjuster's Name_____
Claim No._____ Policy No._____
Attorney's Firm_____ Attorney's Name_____
Attorney's Address_____
Attorney's Phone No._____

- My signature below authorizes the release of any medical or other information acquired concerning my condition or other disabilities, both to and from this acupuncturist, which will assist in the payment of any claim now or in the future. I agree to notify you if there is any change regarding this.
- My signature below authorizes my insurance company to send payments directly to Body in Balance Acupuncture for services rendered to me.
- I understand I am financially responsible for any balance not covered by my insurance carrier.
- My signature below authorizes the provider to send bills directly to my insurance company. I agree to pay the remaining balance within 30 days of receiving an itemized statement. I understand that any delinquent bills sent to collections will incur a 30% additional charge.

Signature_____ Date_____

Body in Balance Acupuncture PLLC
4500 9th Ave NE, Suite 300
Seattle, WA 98105
Phone: (206) 841-8500
Fax: (206) 629-6409

Health History Questionnaire

Date____/____/____

Name:			Sex:
Address:	City:	State:	Zip Code:
Cell Phone:	Home Phone:	Work Phone:	Preferred Phone (Circle): Cell Home Work
Date of Birth:	Age:	Weight:	Height
Occupation:	Employer Name:		
Primary Physician:	Referred By:		
Emergency Contact Name:	Emergency Phone Number:		
Have you been treated by acupuncture before? ☐ Yes ☐ No Chinese herbal medicine? ☐ Yes ☐ No	E-mail:		

What is/are the main problem(s) you would like help with:_____

On a 1-10 scale (10 being severe) how severe is your problem in general? Average:_____ **Peak:**_____

Surgeries (type and date):_____

Significant Trauma (auto accident, falls, etc.):_____

Birth History (prolonged labor, forceps delivery, caesarian section, other):_____

Allergies (drugs, chemicals, foods):_____

Past Medical History: (please include date)

Cancer_____ High Blood Pressure_____ Rheumatic Fever_____ Venereal Disease_____
Diabetes_____ Heart Disease_____ Seizures_____ Asthma_____
Hepatitis_____ Stroke_____ Thyroid Disease_____ Pacemaker_____
Women only: Any chance of being pregnant?_____
Other_____

Medications/Supplements/Other Comments: _____

(Over)

Please Check Any Symptom You Have Had in the Last Three Months. Circle Former Conditions.

General

☐ Chills
☐ Fevers
☐ Sweat easily
☐ Night sweats
☐ Hot Flashes
☐ Bleed or bruise easily
☐ Peculiar tastes or smells
☐ Frequently thirsty
*Is it quenchable?*_____
☐ Fatigue
☐ Sudden energy drop
*Time of day*_____
☐ Edema
*Where:*_____
☐ Poor sleeping
☐ Tremors
☐ Poor Balance
☐ Cravings
☐ Change in appetite
☐ Poor appetite
☐ Weight gain
☐ Weight loss

Skin and Hair

☐ Rashes
☐ Itching
☐ Change in hair or skin
☐ Ulcerations
☐ Eczema
☐ Oozing skin lesion
☐ Hives
☐ Pimples
☐ Recent moles
☐ Loss of hair
☐ Dandruff
Other hair or skin problems
_____
_____

Head, Eyes, Ears, Nose, and Throat

☐ Dizziness
☐ Migraines
☐ Headaches
*When:*_____
*Where:*_____
☐ Facial pain
☐ Glasses
☐ Poor vision
☐ Night blindness
☐ Blurry vision
☐ Color blindness
☐ Blind field
☐ Spots in front of eyes
☐ Eye pain
☐ Eye strain
☐ Cataracts
☐ Eye dryness
☐ Excessive tearing
☐ Discharge from eyes
☐ Poor hearing
☐ Ringing in ears
☐ Earaches
☐ Discharge from ear
☐ Nose bleeds
☐ Sinus congestion
☐ Nasal drainage
☐ Grinding teeth
☐ Teeth problems
☐ Jaw clicks
☐ Concussions
☐ Recurrent sore throats
☐ Hoarseness
☐ Sores on lips or tongue
Other head/neck problems:
_____

Cardiovascular

☐ High blood pressure
☐ Low blood pressure
☐ Chest discomfort/pain
☐ Heart palpitations
☐ Cold hands or feet
☐ Swelling of hands
☐ Swelling of feet
☐ Blood clots
☐ Fainting
☐ Difficulty in breathing
*Other heart/blood vessel problems:*_____

Respiratory

☐ Cough
☐ Asthma/wheezing
☐ Pain with a deep breath
☐ Shortness of breath
☐ Chest tightness
☐ Phlegm. *Color?*_____
☐ Coughing blood
☐ Pneumonia
☐ Bronchitis
*Other lung problems:*_____

Gastrointestinal

☐ Bad breath
☐ Nausea
☐ Vomiting
☐ Heartburn
☐ Belching
☐ Indigestion
☐ Diarrhea
☐ Constipation
☐ Chronic laxative use
☐ Blood in stools
☐ Black stools
☐ Abdominal pain or cramps
☐ Gas
☐ Rectal pain
☐ Hemorrhoids
*Other stomach/intestinal problems:*_____
_____

Genito-Urinary

☐ Pain on urination
☐ Urgency to urinate
☐ Frequent urination
☐ Blood in urine
☐ Decrease in flow
☐ Dribbling
☐ Kidney stones
☐ Impotency
☐ Change of sexual drive
☐ Sores on genitals
Do you wake up to urinate?
☐ Yes ☐ No
*How often?*_____
*Any particular color to your urine?*_____
*Other genital or urinary system problems:*_____
_____

Pregnancy and Gynecology

Number of pregnancies:_____
Number of births:_____
Number of premature births:_____
Number of miscarriages:_____
Number of abortions:_____
Age at first menses:_____
Time between menses (days):_____
Duration of menses (days):_____
First date of last menses:_____
☐ Heavy periods
☐ Light periods
☐ Painful periods
☐ Irregular periods
☐ Changes in body/psyche prior to menstruation (PMS)
☐ Clots
☐ Vaginal discharge
☐ Menopause:
*Age*_____
*Year*_____
☐ Postcoital bleeding
☐ Vaginal sores
☐ Breast lumps
☐ Nipple discharge
Do you practice birth control?
☐ Yes ☐ No
What type and for how long?
_____

Musculoskeletal

☐ Neck pain
☐ Shouler pain
☐ Back pain
☐ Elbow pain
☐ Hand/wrist pain
☐ Hip pain
☐ Knee pain
☐ Foot/ankle pain
☐ Muscle pain
☐ Muscle weakness
Other pain:_____
_____

Neuropsychological

☐ Seizures
☐ Areas of numbness
☐ Localized weakness
☐ Neuropathy
☐ Concussion
☐ Loss of balance
☐ Vertigo
☐ Lack of coordination
☐ Bad temper
☐ Violence potential
☐ Easily susceptible to stress
☐ Depression
☐ Anxiety
☐ Poor memory
☐ Substance abuse
Have you ever been treated for emotional problems?
☐ Yes ☐ No