

# Directions

**Sandra Broberg**

## **Body in Balance Acupuncture**

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

Body in Balance Acupuncture PLLC is located in the University District, on 45<sup>th</sup> Street, just one block west of Roosevelt Avenue. It is 3 blocks west of the U District light rail station and on several major bus lines. From I-5 north or south, take the 45<sup>th</sup> Street exit and head east on 45<sup>th</sup>. Take a left on 9<sup>th</sup> Avenue NE. Take a right on 47<sup>th</sup> and then the first right into the parking lot. My office is located in the University Business Center. Take the elevator to 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.

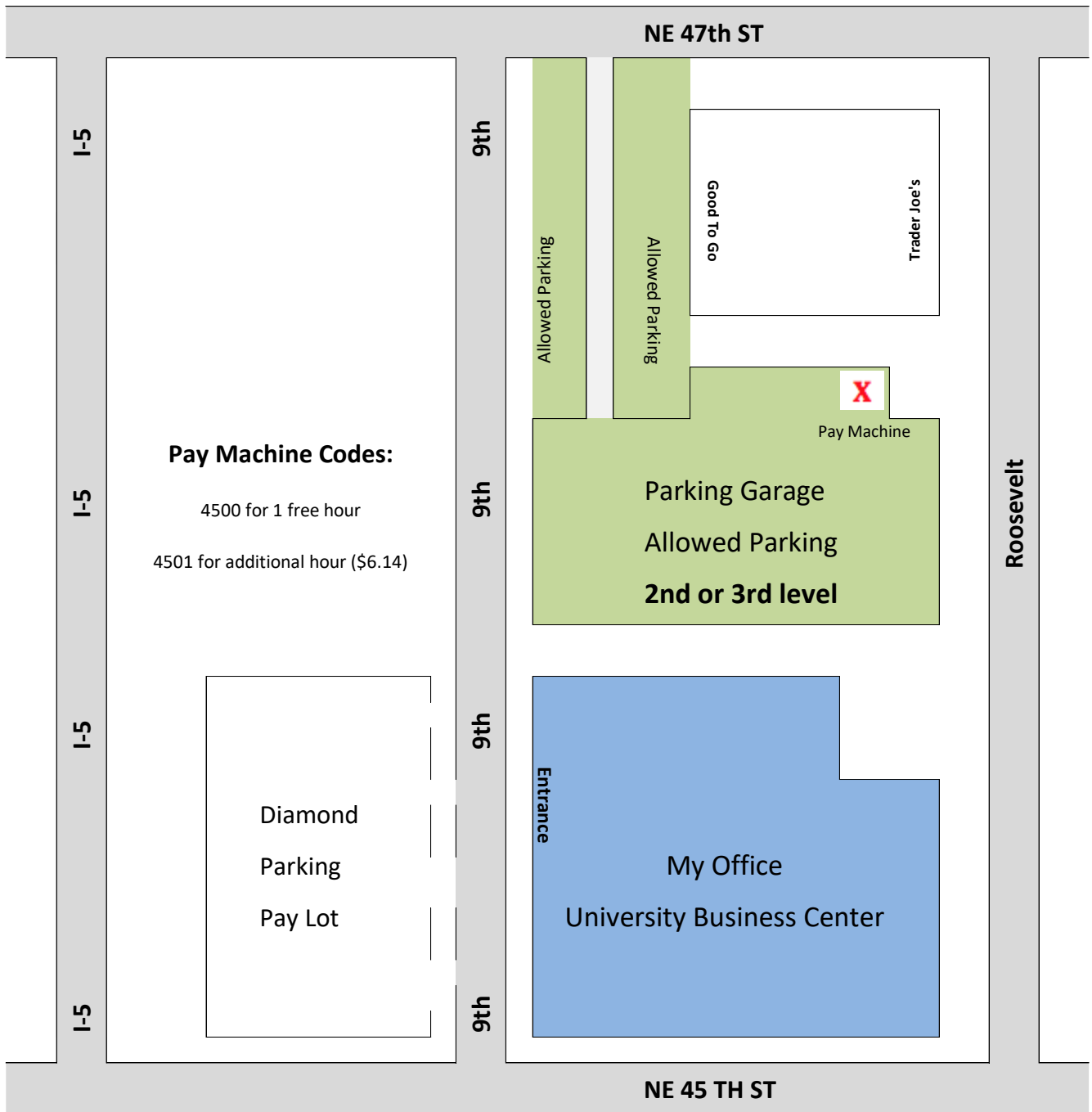
For patients arriving before 8:30, after 5:30, or on weekends, the building or the security gate may be locked. If this occurs, please call 206-841-8500 (this is a landline and does not accept text messages) to let me know you're here, and I'll let you in. If I don't answer, leave a voicemail. I'm likely 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 2<sup>nd</sup> and 3<sup>rd</sup> floor of the parking garage). The parking area is accessed from 47<sup>th</sup> Street, at the corner of 9<sup>th</sup> and 47<sup>th</sup>. (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) Biz Ctr – 1 hour free"
- Enter validation number (4500).
- 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.

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Signature of Patient

Date

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Signature of Person Authorized to Consent

Date



## Body in Balance Acupuncture PLLC

4500 9<sup>th</sup> Ave NE, Suite 300  
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Phone: (206) 841-8500  
Fax: (206) 629-6409

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# Cancellation Policy

(Updated 1-1-2025)

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 \$55 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 \$110.

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 Acupuncture PLLC**

**Sandra Broberg, L.A.C.**

4500 9<sup>th</sup> 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:** \_\_\_\_\_



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## 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 \_\_\_\_\_



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# 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 \_\_\_\_\_



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## 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		E-mail:	
Chinese herbal medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No			

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.

<p><b>General</b></p> <input type="checkbox"/> Chills <input type="checkbox"/> Fevers <input type="checkbox"/> Sweat easily <input type="checkbox"/> Night sweats <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Bleed or bruise easily <input type="checkbox"/> Peculiar tastes or smells <input type="checkbox"/> Frequently thirsty <i>Is it quenchable? _____</i> <input type="checkbox"/> Fatigue <input type="checkbox"/> Sudden energy drop <i>Time of day _____</i> <input type="checkbox"/> Edema <i>Where: _____</i> <input type="checkbox"/> Poor sleeping <input type="checkbox"/> Tremors <input type="checkbox"/> Poor Balance <input type="checkbox"/> Cravings <input type="checkbox"/> Change in appetite <input type="checkbox"/> Poor appetite <input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss	<input type="checkbox"/> Color blindness <input type="checkbox"/> Blind field <input type="checkbox"/> Spots in front of eyes <input type="checkbox"/> Eye pain <input type="checkbox"/> Eye strain <input type="checkbox"/> Cataracts <input type="checkbox"/> Eye dryness <input type="checkbox"/> Excessive tearing <input type="checkbox"/> Discharge from eyes <input type="checkbox"/> Poor hearing <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Earaches <input type="checkbox"/> Discharge from ear <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Sinus congestion <input type="checkbox"/> Nasal drainage <input type="checkbox"/> Grinding teeth <input type="checkbox"/> Teeth problems <input type="checkbox"/> Jaw clicks <input type="checkbox"/> Concussions <input type="checkbox"/> Recurrent sore throats <input type="checkbox"/> Hoarseness <input type="checkbox"/> Sores on lips or tongue <i>Other head/neck problems: _____</i>	<p><b>Gastrointestinal</b></p> <input type="checkbox"/> Bad breath <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Heartburn <input type="checkbox"/> Belching <input type="checkbox"/> Indigestion <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Chronic laxative use <input type="checkbox"/> Blood in stools <input type="checkbox"/> Black stools <input type="checkbox"/> Abdominal pain or cramps <input type="checkbox"/> Gas <input type="checkbox"/> Rectal pain <input type="checkbox"/> Hemorrhoids <i>Other stomach/intestinal problems: _____</i>	<input type="checkbox"/> Heavy periods <input type="checkbox"/> Light periods <input type="checkbox"/> Painful periods <input type="checkbox"/> Irregular periods <input type="checkbox"/> Changes in body/psyche prior to menstruation (PMS) <input type="checkbox"/> Clots <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Menopause: <i>Age _____</i> <i>Year _____</i> <input type="checkbox"/> Postcoital bleeding <input type="checkbox"/> Vaginal sores <input type="checkbox"/> Breast lumps <input type="checkbox"/> Nipple discharge <i>Do you practice birth control?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>What type and for how long? _____</i>
<p><b>Skin and Hair</b></p> <input type="checkbox"/> Rashes <input type="checkbox"/> Itching <input type="checkbox"/> Change in hair or skin <input type="checkbox"/> Ulcerations <input type="checkbox"/> Eczema <input type="checkbox"/> Oozing skin lesion <input type="checkbox"/> Hives <input type="checkbox"/> Pimples <input type="checkbox"/> Recent moles <input type="checkbox"/> Loss of hair <input type="checkbox"/> Dandruff <i>Other hair or skin problems _____</i>	<p><b>Cardiovascular</b></p> <input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Chest discomfort/pain <input type="checkbox"/> Heart palpitations <input type="checkbox"/> Cold hands or feet <input type="checkbox"/> Swelling of hands <input type="checkbox"/> Swelling of feet <input type="checkbox"/> Blood clots <input type="checkbox"/> Fainting <input type="checkbox"/> Difficulty in breathing <i>Other heart/blood vessel problems: _____</i>	<p><b>Genito-Urinary</b></p> <input type="checkbox"/> Pain on urination <input type="checkbox"/> Urgency to urinate <input type="checkbox"/> Frequent urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Decrease in flow <input type="checkbox"/> Dribbling <input type="checkbox"/> Kidney stones <input type="checkbox"/> Impotency <input type="checkbox"/> Change of sexual drive <input type="checkbox"/> Sores on genitals <i>Do you wake up to urinate?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>How often? _____</i> <i>Any particular color to your urine? _____</i> <i>Other genital or urinary system problems: _____</i>	<p><b>Musculoskeletal</b></p> <input type="checkbox"/> Neck pain <input type="checkbox"/> Shoulder pain <input type="checkbox"/> Back pain <input type="checkbox"/> Elbow pain <input type="checkbox"/> Hand/wrist pain <input type="checkbox"/> Hip pain <input type="checkbox"/> Knee pain <input type="checkbox"/> Foot/ankle pain <input type="checkbox"/> Muscle pain <input type="checkbox"/> Muscle weakness <i>Other pain: _____</i>
<p><b>Head, Eyes, Ears, Nose, and Throat</b></p> <input type="checkbox"/> Dizziness <input type="checkbox"/> Migraines <input type="checkbox"/> Headaches <i>When: _____</i> <i>Where: _____</i> <input type="checkbox"/> Facial pain <input type="checkbox"/> Glasses <input type="checkbox"/> Poor vision <input type="checkbox"/> Night blindness <input type="checkbox"/> Blurry vision	<p><b>Respiratory</b></p> <input type="checkbox"/> Cough <input type="checkbox"/> Asthma/wheezing <input type="checkbox"/> Pain with a deep breath <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chest tightness <input type="checkbox"/> Phlegm. <i>Color? _____</i> <input type="checkbox"/> Coughing blood <input type="checkbox"/> Pneumonia <input type="checkbox"/> Bronchitis <i>Other lung problems: _____</i>	<p><b>Pregnancy and Gynecology</b></p> 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: _____	<p><b>Neuropsychological</b></p> <input type="checkbox"/> Seizures <input type="checkbox"/> Areas of numbness <input type="checkbox"/> Localized weakness <input type="checkbox"/> Neuropathy <input type="checkbox"/> Concussion <input type="checkbox"/> Loss of balance <input type="checkbox"/> Vertigo <input type="checkbox"/> Lack of coordination <input type="checkbox"/> Bad temper <input type="checkbox"/> Violence potential <input type="checkbox"/> Easily susceptible to stress <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Poor memory <input type="checkbox"/> Substance abuse <i>Have you ever been treated for emotional problems?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No