

ACUPUNCTURE AND HERBS - COMMUNITY ACUPUNCTURE CLINIC
689 E. 18th St. Chico, CA 95928

Welcome to Our Community!

Please take a few minutes to read this introduction to our community style clinic. We are delighted that you are interested in joining us!

We Offer Treatments Individually or in a Group

Most US acupuncturists treat patients only on tables in individual rooms. Here, we offer private sessions as well as community treatments. In community style acupuncture we use recliners clustered in a quiet, soothing space. The group setting makes it easy for friends and family members to come in for treatment together. Also, sharing a healing space with others creates a collective energy that strengthens each individual treatment. Finally, our group setting allows you to control the length of your treatment.

We Have a Sliding Scale

Our sliding scale is available to everyone. We choose to set our fees this low so that you can receive acupuncture regularly enough to get - and stay - better. Because we prefer to do acupuncture rather than paperwork, we do not do insurance billing or receive grants. We are able to offer acupuncture at such affordable prices because we see multiple people per hour and streamline our treatments - we rely mostly on traditional pulse and tongue diagnosis to decide how to treat you, and do very little talking. We can set up more in depth consultation sessions as the need arises.

Our Services and Commitment That We Offer You

In addition to acupuncture, we offer herb/nutrition/self-care consultations. Your practitioner may suggest that you schedule a consultation as part of your treatment plan. We want to give you the tools to take care of your own health. We are committed to being skilled practitioners and to creating a safe, comfortable, and welcoming environment.

What We Request of You

Response-Ability

Please understand that acupuncture is not a substitute for Western medicine. While we can provide complementary care for conditions that are being treated by others - for instance, treatment to counteract the side effects of chemotherapy - you need to see a Western physician for serious conditions.

Continued ->

Flexibility and Community-Mindedness

The soothing atmosphere in our community room exists because we all create it. Please help preserve the collective stillness by lowering your voice or whispering. Feel free to bring whatever you need to make yourself comfortable: water bottle, a favorite pillow, shawl, or earplugs to block the occasional snorer. And of course, we greatly appreciate your turning off your **cell phone** and not using scented products.

Familiarity with our Routine

The Consultation Room and the Community Treatment Room are directly behind the main house. Use the entrance on the left and walk all the way back. Check in first at the Consultation Room up the low stairs. Paying for your session and scheduling your next appointment *before* your treatment will allow you to relax and forget about these things during and after your treatment. Before treatment, please store your personal belongings, (bags, shoes, etc.) in the basket by your chosen treatment spot. If you need to have your needles removed at a certain time, tell your practitioner and we'll make sure you're out on time. Otherwise, when you feel your treatment is done, open your eyes and give us a meaningful look - if your eyes are closed, we think you're asleep and we won't wake you up.

Commitment

Acupuncture is a healthful *process*. It is possible but rare for any acupuncturist to resolve a problem with only one treatment. On your first visit, we will suggest a course of treatment, which can be anything from "we'd like to see you once a week for six weeks" to "we'd really like to see you daily for the next four days". To get good results, it's important that you commit to the treatment process.

Growing our Community

We believe that in Chico, Community Style Acupuncture can play a vital role in keeping health costs down and keeping our community healthy. If you share this belief, please help us develop this sustainable business model. Please take some cards and hand bills to pass around or write us a testimonial.

And, last, but not least....enjoy the space. We do, and we hope that we can be an important part of your healing journey.

Thank you,

Adam Moes L.Ac

530.828.2589

www.MyChineseHerbalist.com

Acupuncture and Herbs

689 East 18th Street

Chico, CA. 95928

NAME _____ DATE _____
(First) (Last)

ADDRESS _____
(Number and street) (city) (ZIP code)

TELEPHONE: home _____ work _____

E-MAIL ADDRESS: _____

Occupation _____ Employer _____

Are you exposed to any toxic chemicals through your work? _____

BIRTHDATE _____ HEIGHT _____ WEIGHT _____

Do you have any children? ___ How many? ___ Ages _____

Marital Status: Married ___ Single ___ Relationship ___ Divorced ___ Widowed ___

How did you find us? Friend (name) _____

Phone book (which?) () AT&T () Valley () Yellow Book () Butte

Advertisement (where?) _____

Professional referral (name) _____

Other _____

Please briefly describe your health condition: _____

Please list your health goals:

1. _____

2. _____

3. _____

Are you under other medical care? ___ reason? _____

Are you taking any medication? ___ please list:

Substance _____ dosage _____ reason _____

Substance _____ dosage _____ reason _____

Substance _____ dosage _____ reason _____

Substance _____ dosage _____ reason _____

List any allergies: 1. _____ 2. _____ 3. _____

NAME _____ DATE _____

If you currently experience any symptoms, placed a check.
If the symptoms are severe, marked with an X

- | | | |
|---|---|--|
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Muscle spasms |
| <input type="checkbox"/> Painful urination | <input type="checkbox"/> Tendency to become obsessive
in work or relationships | <input type="checkbox"/> Painful joints |
| <input type="checkbox"/> Incontinence | <input type="checkbox"/> Easily fatigued | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Urinary retention | <input type="checkbox"/> Weak limbs | <input type="checkbox"/> Muscular pains |
| <input type="checkbox"/> Wake up to urinate | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Tight or painful neck |
| <input type="checkbox"/> Dark colored urine | <input type="checkbox"/> Mentally restless | <input type="checkbox"/> Tight or painful shoulders |
| <input type="checkbox"/> Urethral discharge | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Chest pains | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Impaired hearing | <input type="checkbox"/> Leg cramps | <input type="checkbox"/> Heat intolerance |
| <input type="checkbox"/> Ear ringing | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cold intolerance |
| <input type="checkbox"/> Low sex drive | <input type="checkbox"/> Anemia | <input type="checkbox"/> Brittle nails |
| <input type="checkbox"/> Impotence | <input type="checkbox"/> Ankle swelling | <input type="checkbox"/> Bitter taste |
| <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Feverish extremities | <input type="checkbox"/> Lump in the throat |
| <input type="checkbox"/> Knee problems | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Pains under ribs |
| <input type="checkbox"/> Afternoon fatigue | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Enlarged lymph nodes |
| <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Other stones | <input type="checkbox"/> Other sleep difficulties | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Eye problems |
| <input type="checkbox"/> Loose stools | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Can't digest oily foods |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Easily angered |
| <input type="checkbox"/> Difficult to awaken | <input type="checkbox"/> Easily chilled | <input type="checkbox"/> Difficulty making decisions
or plans |
| <input type="checkbox"/> Edema | <input type="checkbox"/> Excessive sweating | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Easily bruised | <input type="checkbox"/> Cough | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Difficult to stop bleeding | <input type="checkbox"/> Dry cough | <input type="checkbox"/> Gallstones |
| <input type="checkbox"/> Sudden weight loss | <input type="checkbox"/> Dry skin | <input type="checkbox"/> Light colored stools |
| <input type="checkbox"/> Sores in mouth | <input type="checkbox"/> Sore throat | <input type="checkbox"/> Hair loss |
| <input type="checkbox"/> Cold stomach | <input type="checkbox"/> Sinus congestion | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Cold abdomen | <input type="checkbox"/> Asthma | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Sores on the tongue | <input type="checkbox"/> Decreased sense of smell | <input type="checkbox"/> Blood in stools |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Nasal problems | <input type="checkbox"/> Black tarry stools |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Skin problems | <input type="checkbox"/> Dandruff |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Rashes | <input type="checkbox"/> Cold hands |
| <input type="checkbox"/> Nausea and vomiting | <input type="checkbox"/> Feeling of claustrophobia | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Hickups or belching | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Dry mouth |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Allergies | <input type="checkbox"/> Heated palms |
| <input type="checkbox"/> Increased thirst | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Resting perspiration |
| <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Intolerance to
weather change | |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Metallic taste | |
| <input type="checkbox"/> Bloating after meals | | |
| <input type="checkbox"/> High cholesterol | | |
| <input type="checkbox"/> Colitis | | |
| <input type="checkbox"/> Diverticulitis | | |

Please answer the following questions

Y for yes **N** for no.

For Men and Women:

- Do you smoke?
- Do you drink alcohol on a regular basis?
- Have you had recent unexplained weight loss or gain?
- Do you drink soft drinks? How many per day? ____
- Do you eat spicy food?
- Do you crave salt, or sugar, or other tastes of food?
- Do you exercise regularly?
- Have you noticed any skin thickening or lumps?
- Do you have any sores that haven't healed?
- Have you noticed any unusual bleeding or discharge?
- Have you noticed any change in bowel movements?
- Do you sleep well?
- Do you have indigestion regularly?
- Do you have a cough or hoarseness of voice?
- Have you noticed a change in any moles you may have?
- Do you take non-prescription drugs on a regular basis?
- If this is a chronic condition, do you have any idea what may be causing it?

For women:

Are you pregnant? ____yes ____no ____maybe

Duration of menstrual cycle:

____ days between periods, flow lasts ____ days

FEE SCHEDULE

Acupuncture treatment:

- \$60.00 One hour treatments in your own room
- \$20-40.00 Community clinic treatments
- \$15-40.00 Community clinic treatments - more than one visit per week

Consultation:

- \$40.00 One half hour life coaching, dietary consultation, and explanation of treatment plan
- \$30.00 Herbal consultation - Initial
- \$10.00 Herbal consultation - Follow up

Massage:

- \$60.00 One hour massage
- \$95.00 One and a half hour massage

Product

- \$25.00 Custom herbal formula - 100dram (three weeks supply)

Acupuncture and Herbs

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Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Health care Operations

I understand that as part of my health care, Acupuncture and Herbs originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and medical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

(Signature) _____

(Date) _____

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro. rata share of the expenses and, fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties Consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____ Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE **X** _____

(Or Patient Representative)

(Indicate relationship if signing for patient)

OFFICE SIGNATURE **X** _____

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on 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 employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although Acupuncture and Herbs uses only sterile single use, disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping.

I understand that while this document describes the major risks of treatment; other side effect and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral 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 will notify a clinical staff member who is caring for me if I am or become pregnant.

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

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above 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.

PATIENT SIGNATURE **X** _____

(Or Patient Representative)

(Indicate relationship if signing for patient)