Welcome to Our Community!

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

What is different about this clinic?

- **We treat in a community setting -**

Most US acupuncturists treat patients on tables in individual cubicles. This is not traditional in Asia, where acupuncture usually occurs in a community setting. In our clinic we primarily use recliners, clustered in groups in a large, quiet, soothing space. Treating patients in a community setting has many benefits: it's easy for friends and family members to come in for treatment together; many patients find it comforting; and a collective energetic field becomes established which actually makes individual treatments more powerful. In some styles of acupuncture, the needles are removed after only a few minutes or after a half hour at most. The style of acupuncture we practice at WCA allows patients to keep their needles in as long as they want, and the "right" amount of time varies from patient to patient. Most people learn after a few treatments when they feel "done"; this can take from twenty minutes to a couple of hours! Many people fall asleep, and wake feeling refreshed.

- **We have a sliding scale -**

Most US acupuncturists also see only one patient per hour and charge $65 to $175 per treatment. They tend to spend a long time talking with each patient, going over medical records, asking many questions. We don't. The only way that we at WCA can make acupuncture affordable and still make a living ourselves is to streamline our treatments and see multiple patients in an hour, so we have returned to the traditional approach; instead of asking you lots of questions, we rely on pulse diagnosis to decide how to treat you. This is exactly how acupuncture is practiced traditionally in Asia -- many patients per hour and very little talking.

Please see the enclosed form that explains our sliding scale. Because we have a sliding scale, we cannot do insurance billing (that's the insurance companies' rule). If you have insurance that covers acupuncture, we'll be happy to give you a payment receipt, and you can submit it; that's OK with the insurance companies.

Our Commitment to You

We want to make it possible for you to receive acupuncture regularly enough and long enough to get better and stay better. We want our community to be welcoming to all different kinds of people. We want to give you the tools to take care of your own health so that you will not need to rely on corporations like Big Insurance or Big Pharmaceuticals for costly, high-tech interventions.

What We Need From You

♦ Responsibility

WCA does not provide primary care medicine! Acupuncture is a wonderful complement to Western medicine, but it is not a substitute for it. If you think you have a problem that is not "garden variety" (meaning, you are worried that you might have a serious infection, a malignant growth, or an injury that won't heal), or if you want someone knowledgeable to go over the details of your medical history with you, you need to see a primary care physician (ND, MD, or DO). We can provide some excellent, affordable referrals, even if you have no insurance coverage. But you cannot expect us to diagnose and treat something really serious. We *can* provide complimentary care for conditions which require a physician's attention, but we need you to take responsibility for your own health.

Arizona Acupuncture LLC does not receive grants, state or federal money, or insurance reimbursement. This clinic exists because patients pay for their treatments – it a sustainable community business model.

♦ Flexibility
The community setting requires some flexibility from you. For instance, many patients have a favorite recliner. When we are busy, someone may be sitting in yours. Similarly, we have a few patients who snore. Other patients who dislike snoring bring earplugs to their treatments. We are grateful for this! Some of our patients even bring favorite pillows or blankets from home with them, because they prefer theirs to ours. That's fine with us. Basically, we need you to participate in making yourself comfortable in the community room before we arrive to treat you.

In terms of how long you want to stay -- tell me or the receptionist, when you check in, if you need to be somewhere at a certain time! If you want to be unpinned at a specific time, ask her to make a note and give it to the acupuncturist. We'll make sure you're out on time. In general, if you feel 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.

♦ Community-Mindedness
The soothing atmosphere in our clinic exists because all of our patients create it by relaxing together. We appreciate everyone's presence! This kind of collective stillness is a rare and precious thing in our rushed and busy society. Maintaining this reservoir of calm requires that no one talk very much in the clinic space. If you would like to speak to a practitioner one-on-one at any length, please let us know. If you want to have a substantial conversation, we will probably need to schedule that separately and might need to do it by phone.

If you have questions about acupuncture and how it works -- please read the Little Red Book for Patients. Several copies are available in the waiting area for you to read and leave in the clinic for the next patient.

Part of our success is that our patients learn the "routine" and take on a lot of responsibility for the appointments. Re-scheduling and making payment happens at the front desk BEFORE each treatment, so you can relax and enjoy treatment. Please take all personal belongings, (bags, shoes, etc.) with you back into the treatment room. And of course, please turn off your cell phone.

♦ Commitment
Acupuncture is a PROCESS. It is very rare for any acupuncturist to be able to resolve a problem with one treatment. In China, a typical treatment protocol for a chronic condition could be acupuncture every other day for three months! Most of our patients don't need that much acupuncture, but virtually every patient requires a course of treatment, rather than a single treatment, in order to get what they want from acupuncture.

One big reason that we are able to keep our prices so low is because of the extraordinary amount of marketing our patients do on our behalf -- we don't have to advertise. We cannot express how grateful we are for this. Our patients are such effective marketers because they have first-hand experience of how well acupuncture works. All of our satisfied patients basically made a commitment to a course of treatment.

On your first visit, your acupuncturist 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 every day for the next four days". This suggestion is based on our experience with treating different kinds of conditions. If you don't come in often enough or long enough, acupuncture probably won't work for you. The purpose of our sliding scale is to help you make that commitment. If you have questions about how long it will take to see results, please ask us, or if you think you need to adjust your treatment plan, please let us know. We need you to commit to the process of treatment in order to get good results.

And, last, but not least….enjoy the space. We do, and hope that Working Class Acupuncture can be an important part of your community. Thank you,

Arizona Acupuncture LLC ~ Yuma's Community Style Acupuncture

Arizona Acupuncture LLC
Yuma's Community Style Acupuncture

Sheila A. Condit L.Ac. MSOM
3325 S. Avenue E
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Phone: (928) 503-4380

Notice of Privacy Practices

We are dedicated to providing service with respect to human dignity. Protecting your privacy and your healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in the law.

I. Understanding Your Health Record/Information

Each time you visit a hospital, physician, acupuncturist, chiropractor, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

a) basis for planning your care and treatment
b) means of communication among the many health professionals who contribute to your care
c) legal document describing the care you received
d) means by which you or a third-party payer can verify that services billed were actually provided
e) a tool for educating heath professionals
f) a source of data for medical research
g) a source of information for public health officials charged with improving the health of the nation
h) a source of data for facility planning and marketing
i) a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

a) ensure its accuracy
b) better understand who, what, when, where, and why others may access your health information
c) make more informed decisions when authorizing disclosure to others

II. Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

a) request a restriction on certain uses and disclosures of your information
b) obtain a paper copy of this Notice of Privacy Practices upon request
c) inspect and obtain a copy of your health record
d) amend your health record under certain circumstances
e) obtain an accounting of disclosures of your health information
f) request communications of your health information by alternative means or at alternative locations
g) revoke your authorization to use or disclose health information except to the extent that action has already been taken

III. Our Responsibilities

Arizona Acupuncture is required to:

a) maintain the privacy of your health information
b) provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
c) abide by the terms of this notice
d) notify you if we are unable to agree to a requested restriction
e) accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you supply to us.

We will not use or disclose your health information without your authorization, except as described in this notice.

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IV. For More Information or to Report a Problem

If have questions and would like additional information, ask your provider for clarification. If you believe your privacy rights have been violated, you can file a complaint with the U.S. Department of Health and Human Services, Office of Civil Rights. You can find the Office for Civil Rights for your state at: http://www.hhs.gov/ocr/regmail.html.There will be no retaliation for filing a complaint.

V. Examples of Disclosures for Treatment, Payment and Health Operations

Needless-to-say, we will disclose your protected health information in communications with you. For example, we may use and disclose health information to contact you as a reminder that you have an appointment for treatment here, or to tell you about or recommend possible treatment options or alternatives that might be of interest to you. We may use and disclose health information about you to tell you about health-related benefits or services that might be of interest to you. Other reasons to disclose your health information include the following.

1) *We will use your health information for treatment.*
For example: Information obtained by your practitioner will be recorded in your record and used to determine the course of treatment that should work best for you. Your provider will document in your record his or her expectations of any other members of your healthcare team. Those team members will then record the actions they take and their observations. In that way, the practitioner will know how you are responding to treatment.

2) *We will use your health information for payment.*
For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular clinic operations.

For example: Members of the clinic staff may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the service we provide.

3) *Business associates*
There are some services provided in our organization through contacts with business associates. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered, if appropriate. To protect your health information, however, we require the business associate to appropriately safeguard your information.

4) *Directory*
Unless you notify us that you object, we may use your name, general condition, and religious affiliation for directory purposes.

5) *Notification*
We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

6) *Communication with family*
Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

7) *Research*
We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

8) *Coroners, medical examiners and funeral directors*
We may disclose health information to coroners, medical examiners and funeral directors consistent with applicable law to carry out their duties.

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9) *Organ procurement organizations*
Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

10) *Marketing*
We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

11) *Food and Drug Administration (FDA)*
We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

12) *Workers compensation*
We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

13) *Public health*
As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

14) *Correctional institution*
Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

15) *Law enforcement*
We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

16) *Health oversight*
Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct, or have otherwise violated professional or clinical standards, and are potentially endangering one or more patients, workers or the public.

17) *As required by law*
We will disclose health information about you when required to do so by federal, state, or local law. For example, information may need to be disclosed to the Department of Health and Human Services to make sure that your rights have not been violated.

18) *Suspicion of abuse or neglect*
We will disclose your health information to appropriate agencies if relevant to a suspicion of child abuse or neglect, or, if you are not a minor, if you are a victim of abuse, neglect or domestic violence and either you agree to the disclosure or we are authorized by law to disclose this and it is believed that disclosure is necessary to prevent serious harm to you or others.

19) *To avert a serious threat to health or safety*
We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety, or to the health and safety of the public or another person. Any disclosure, however, would only be to someone who we believe would be able to prevent the threat or harm from happening.

20) *For special government functions*
We may use or disclose your health information to assist the government in its performance of functions that relate to you. For example, if you are a member of the armed forces, this might include sharing your information with appropriate military authorities to assist in military command.

Effective Date: November 1, 2011

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

I, ____, have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barrier prohibited obtaining the acknowledgement

☐ Other (Please Specify) ______________________________________

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Informed Consent to Release Information

HIPAA privacy regulations stipulate that health care providers may not use or disclose a patient's health information without his or her authorization, except as described in the Notice of Privacy Practices. That document clarifies the conditions under which a patient's information may be released without his or her authorization, and when an express authorization is required by the patient.

Under certain circumstances, it may become necessary for this office to release a patient's health information to an individual or entity outside of this office. In accordance with the Notice of Privacy Practices, this office, via this authorization form, requests that the patient indicated below authorize the release of his/her health information.

I, the undersigned, understand that I have the right to:
- refuse to sign this authorization
- receive a copy of this authorization
- restrict what is disclosed by this authorization
- inspect or request an amendment of the health information to be disclosed
- revoke this authorization, by written notice
- know about any compensation the practitioner/facility will receive resulting from the release of my health information

I recognize that once disclosed my health information is no longer under the control of this practitioner/facility. While I understand that the practitioner/facility will make a good faith effort to release my information only to trusted recipients, my health information may be re-disclosed by subsequent parties, and thus may no longer be protected by Arizona Acupuncture office's privacy practices.

I understand that whether or not I sign this document will not effect my treatment at this practice, the payments I incur here, or my eligibility for benefits of any sort. If I do experience any such negative repercussions, I have the right to file a complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services. I can find the Office for Civil Rights for my state at: http://www.hhs.gov/ocr/regmail.html.

Patient Name: ____

Address: ____

Date of Birth: ____

Health information to be disclosed: ____

Individual(s), entities or business associates to receive this health information: ____________________

____

Specific purpose of this disclosure: ____

____

Effective dates of this authorization: ____/____/____ through ____/____/____
(The authorization will expire at the end of this period)

I hereby authorize this office to disclose my health information as described in this document.

____
Signature of Patient (or authorized representative) Date

____
Signature of Practitioner or Facility Representative Date

YUMA'S COMMUNITY STYLE ACUPUNCTURE

3325 S. AVENUE 8E, YUMA, AZ 85365
(928) 503-4380 WWW.AZ-ACUPUNCTURE.COM

PATIENT INFORMATION

Date____

Name_______________________________________

Address_____________________________________

City State Zip________________________________

Age__________ Birthdate ____________________

Occupation _________________________________

Company name ______________________________

Primary physician ____________________________

Physician phone number______________________

How did you hear about us?___________________

____

CONTACT INFORMATION

Home phone ______________________________________

Work phone ______________________________________

Other/cell phone __________________________________

Email ____

Another person we may contact if needed:

Name ____

Relationship______________________________________

Home phone ______________________________________

Work phone_______________________________________

HEALTH HISTORY

What are your primary concerns for coming in for treatment?

1- ____

2 - ____

3 - ____

How is your sleep? ____________________________

____

How is your digestion? _________________________

____

List medications or food supplements you are taking.

____

____

List serious illnesses, accidents or surgeries.

____

____

Check illnesses that have occurred in blood relatives.

. Diabetes . High blood pressure . Stroke
. Cancer . Heart disease . Kidney disease

Check symptoms you have or have had in the last year:

- □ Depression
- □ Difficulty in focusing
- □ Dizziness
- □ Easily startled
- □ Excessive worry
- □ Excessive anger
- □ Excessive fear
- □ Fatigue/tiredness
- □ Headaches
- □ Loss of sleep/poor sleep
- □ Loss or gain of weight
- □ Nervousness/irritability
- □ Overwhelmed by life

Check conditions you have or have had in the past:

- □ AIDS
- □ Allergies
- □ Anemia
- □ Arthritis
- □ Bleeding disorders
- □ Breast lump
- □ Cancer
- □ Diabetes

How long has it been since you have had a complete medical exam? ____________________________

HEALTH HISTORY…CONTINUED

Check symptoms you have or have had in the last year:

MUSCLE/JOINT/BONES

- ☐ Tremors c Cramps
- ☐ Swollen joints

Pain, weakness, numbness in:

- ☐ Arms or Hips
- ☐ Back Legs
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulders
- ☐ Other___________________

EYES/EAR/NOSE/THROAT/RESPIRATORY

- ☐ Asthma/wheezing
- ☐ Blurred or failing vision
- ☐ Difficulty breathing
- ☐ Earache
- ☐ Enlarged glands
- ☐ Eye pain
- ☐ Frequent colds
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Gum trouble
- ☐ Nose bleeds
- ☐ Loss of hearing
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems

SKIN

- ☐ Boils
- ☐ Bruise easily
- ☐ Dry skin
- ☐ Itching/rash
- ☐ Sensitive skin
- ☐ Sore won't heal
- ☐ Sweats

GENITO/URINARY

- ☐ Blood/pus in urine
- ☐ Frequent urination
- ☐ Inability to control urine
- ☐ Kidney infection/stones
- ☐ Lowered libido

CARDIOVASCULAR

- ☐ Chest pain
- ☐ Hardening of arteries
- ☐ High or low blood pressure
- ☐ Pain over heart
- ☐ Poor circulation
- ☐ Previous heart attack
- ☐ Rapid/irregular heart beat
- ☐ Swelling of ankles

GASTROINTESTINAL

- ☐ Belching, gas or bloating
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Distention of abdomen
- ☐ Excessive hunger
- ☐ Gall bladder trouble
- ☐ Hemorrhoids (piles)
- ☐ Indigestion
- ☐ Nausea
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting

FOR MEN ONLY

- ☐ Erection difficulties
- ☐ Penis discharge
- ☐ Prostate trouble

FOR WOMEN ONLY

- ☐ Bleeding between periods
- ☐ Clots in menses
- ☐ Excessive menstrual flow
- ☐ Extreme menstrual pain
- ☐ Irregular cycle
- ☐ Menopausal symptoms
- ☐ PMS
- ☐ Previous miscarriage
- ☐ Scanty menstrual flow

Could you be pregnant?_____________

SIGNATURE

The information on this form is correct to the best of my knowledge.

Signature____ Date _______________________

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Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture, Chinese medicinal herbs and Oriental medicine by a Licensed Acupuncturist at Arizona Acupuncture. I understand that acupuncturists practicing in the state of Arizona are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended.

Initial here_____ **Acupuncture / Moxibustion:** I understand that acupuncture is performed by the insertion of single use sterile needles through the skin, application of low intensity laser light on the skin or by the application of heat to the skin at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. Acupuncture and Moxibustion are typically safe methods of treatment, however certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, dizziness, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop the acupuncture treatment at any time.

Initial here_____ **Pregnancy:** I will notify the acupuncturist should I become pregnant or if I am in the process of trying to become pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

Initial here_____ **Direct Moxibustion:** I understand that if I receive direct moxibustion as part of therapy, ***there will likely be burning or scarring the skin from its use.*** In fact, burning and scarring may even be a part of the therapeutic action, and may be intentional, on the part of the practitioner. I understand that I may refuse this therapy.

Initial here_____ **Chinese Medicinal Herbs:** I understand that Chinese medicinal herbs may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, nausea & vomiting, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems, which I associate with these substances, I should suspend taking them and call Arizona Acupuncture as soon as possible.

Initial here_____ **Acupressure / Tui-Na / Seifukujutsu Massage:** I understand that I may also be given acupressure / tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse the treatment or stop the treatment at anytime for any reason.

Initial here_____ **Cupping / Gua Sha:** I understand that I may also be given cupping (the application of glass cups with vacuum to the skin) and Gua Sha (rubbing of the skin with a smooth object such as a porcelain spoon) as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. ***I am aware that these treatments are intended to cause minor bruising and though unsightly are not normally painful***. However certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse the treatment or stop the treatment at anytime for any reason.

Initial here_____ **Electro-Acupuncture:** I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I do not expect Sheila A. Condit or Arizona Acupuncture to be able to anticipate and explain all possible risks and complications of treatment. I have carefully read and understand all the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation of anything regarding my treatment. I understand that my records will be kept confidential and will not be released without my written consent (unless in an emergency or by legal demand). I give my permission and consent to treatment.

Signature: ____ **Date:** ________________________

Printed Name: ____**Date of Birth:** ___________________