Welcome to

# COMMUNITY ACUPUNCTURE ALBUQUERQUE

Please take a moment to read this introduction to the clinic.
We are delighted that you are interested in joining us!
www.commacupabq.org
**We are located at 2509 Vermont NE, Suite A2, Albuquerque, NM, 87110.**

**We are taking appointments only during the Coronavirus Pandemic and beyond – sorry no walk-ins. Check our current hours on our website. You can book online at our website, or phone, text or email**
**www.commacupabq.org commacupabq@gmail.com 505 266 2606**

**New Patients** need to fill out new patient paperwork, send us a proof of vaccination or recent immunity (positive test from12/15/21 onwards) and watch a brief orientation to check-in video. New patient fees are $40-60 and current patient fees are $20-$50, sliding scale (pay whatever you are comfortable with).

## *What is different about Community Acupuncture?*

- **We treat in a community setting**

We treat in a community setting using chairs safely spaced in a large, quiet, soothing, well-ventilated space. Most US acupuncturists treat patients on tables in individual cubicles which is not traditional in Asia. Treating patients in a community setting has many benefits: It's easy for friends and family members to come in for treatments together; many patients find it comforting; and a collective energetic ("qi") field becomes established which makes individual treatments more powerful.

- **We charge an affordable fee**

We charge $20-$50 per treatment (sliding scale), with an initial assessment fee of $20. Most US acupuncturists see one or two patients per hour and charge $60-$180 per treatment and tend to spend a long time talking with each patient. We don't. This model allows us to make acupuncture affordable to everyone while still making a living ourselves. Instead of asking you lots of questions, we rely on our diagnostic skills to treat you. This is exactly how acupuncture is practiced traditionally in Asia—many patients per hour and very little talking. We want to make it possible for you to receive acupuncture regularly and long enough to get better and stay better.

## *What We Need from You*

- **Medical Responsibility**

We don't provide primary care medicine. Acupuncture is an excellent complement to Western medicine, but is not a substitute for it. If you have, or think you may have, a potentially serious condition—a malignant growth, serious infection, unexplained weight loss or gain, severe abdominal pain, etc. --- or if you want someone knowledgeable to go over the details of your medical history, you need to see a primary care physician. We can provide some excellent, affordable referrals, even if you have no insurance coverage. We can also provide complementary care for conditions which require a physician's attention—for instance we often treat patients for the side effects of chemotherapy. However, we are not able to diagnose serious conditions and we do need you to take responsibility for your health.

- **Community Mindedness**

The soothing atmosphere in our clinic exists because all our patients create it by relaxing together. We appreciate everyone's presence. Such collective stillness is rare and precious in our rushed society. Maintaining this reservoir of calm requires that we speak softly when necessary. Please turn off cell phones when you enter. Please do not wear perfume, aftershave, essential oils, or anything that is heavily scented as some of our patients and staff get ill from these.

- **Communication**

Let us know at the beginning of the treatment if you need to be somewhere at a certain time or if you want to be unpinned after a specific amount of time. If your eyes are closed we will think you are asleep and we won't wake you. Let us know if you need help with anything or are cold or uncomfortable in any way. Clear your throat to get our attention and catch our eye.

- **A Little Help Running the Clinic**

*On booking:* We will screen for COVID symptoms and risks. If you have any of the covid symptoms please cancel – there will be no cancellation fee. Please follow NM current public health regulations regarding travel and isolation. You can find them here cv.nmhealth.org or an update on our website.

*Before entering.* Leave family and friends at home. If you need physical help getting into the clinic or your chair, bring someone to help you who will leave and come back (we do not have a receptionist and the acupuncturist will be busy with other patients.) Put your face covering on. (Now is a good time to turn your cell phone off)

*Check-in:* When you enter the clinic, the check in desk is in front of you. Please wait outside if someone is ahead of you. Sanitize your hands, then fill out the COVID certification form. Take your own temperature and write it on the form. Fill out a payment slip with amount, name, date and time and whether you are paying cash, check or credit card. For cash, we do not give change so please bring the exact amount. Make checks out to PHANM, Community Acupuncture, or CAA. For credit card, use the ipad. Instructions are pasted on the desk. Put payment in a blank envelope and place in the black mail box—***do not seal or fold***. If you need to leave a message for us, leave a note in the envelope and please date the note. Note: we do not bill insurance companies or provide CPT or Diagnostic codes - you can fill out a receipt which can be found behind the payment envelopes, take it to the chair with you and the acupuncturist will sign it for you.

The bathroom is to the left. Turn your cellphone to vibrate or off.

When you are shown into the clinic area, find a chair and make yourself comfortable. Please bring all personal belongings back to the treatment area and put everything *under* the chair in the plastic box. Sit down before removing your shoes and socks, then tuck them under the chair. Raise your sleeves above your elbows and your pants to just below your knees.

- **Commitment**

Acupuncture is a PROCESS and the effect of multiple treatments is cumulative. It is rare for any acupuncturist to be able to resolve a problem within one treatment. In China, a typical treatment protocol for a chronic condition could be acupuncture every other day for three months! or for ten days in a row. Most people don't need that much acupuncture, but virtually every patient requires a course of treatment which varies in length and frequency. Normally, you should know after 6 treatments if the treatments are helping. We want you to be able to come in often enough to really get better and stay better. Your acupuncturist will tell you how frequently they recommend, or look at our "How often should I come?" guidelines on the website.

- **Some other things**

It is best to have eaten something at least a few hours before treatment but not a heavy meal, so that you are comfortable. Wear clothes that are loose up to your knees and elbows. Don't wear scented products including essential oils. Once you are settled in your chair with your shoes and socks off, the acupuncturist will come to you. They will sometimes look at your tongue, sometimes take your pulses, and ask you a few questions. They will then insert a few needles (all needles are single use only and are disposed of safely). You may feel any of the following sensations on needling – warmth, cold, itchy, electrical, swelling, slight cramping, traveling (you may feel the sensation in a different place than the needle). If you feel sharpness, it should be momentary, if it persists or any needles are uncomfortable, let the acupuncturist know. Clear your throat theatrically to call them. Now, lie back and relax!

When you are ready to leave (maybe 30 minutes or maybe longer), clear your throat and open your eyes to let us know you are done. The acupuncturist will come and remove the needles and you can leave.

Enjoy the space!

PHANM - CAA. PO Box 35863, Albuquerque, NM 87176
505 266 2606 CommAcupAbq@gmail.com

# COMMUNITY ACUPUNCTURE ALBUQUERQUE

*2509 Vermont NE, Suite A2, Albuquerque, NM 87110*

*505-266-2606 ~ CommAcupAbq@gmail.com www.CommAcupAbq.org*

## PATIENT INFORMATION

Date_____

Name_____

Address_____

City State Zip_____

Age_____ Height _____ Weight_____

Occupation _____

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 - _____

List medications or food supplements you are taking. (General area of use is OK eg Diabetes meds)

_____

_____

_____

_____

List serious illnesses, accidents or surgeries (date).

_____

_____

_____

_____

**Check illnesses that have occurred in blood relatives.**

□Diabetes □High blood pressure □Stroke
□Heart disease □Kidney disease □Asthma
□Hayfever □Migraines
□Cancer *type*_____

**Check conditions you have or have had in the past:**

- □ HIV/AIDS
- □ Allergies
- □ Anemia
- □ Arthritis
- □ Asthma
- □ Addiction
- □ Bleeding disorders
- □ Breast lump
- □ Cancer *type*_____
- □ Diabetes
- □ Glaucoma
- □ Hepatitis C or B
- □ High Blood Pressure
- □ Pneumonia
- □ Seizures
- □ Stroke
- □ TB

**Check symptoms you have or have had in the <u>last year</u>:**

- □ Depression
- □ Difficulty in focusing
- □ Dizziness
- □ Mood problems
- □ Fatigue/tiredness
- □ Headaches
- □ Loss of sleep/poor sleep
- □ Loss of weight
- □ Gain of weight

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

## HEALTH HISTORY…CONTINUED

**Check symptoms you have or had in the <u>last year</u>:**

**MUSCLE/JOINT/BONES**

- □ Tremors
- □ Cramps
- □ Swollen joints
- □ Weakness
- □ Numbness

Pain in:

- □ Neck
- □ Upper Back
- □ Hips
- □ Middle Back
- □ Thighs
- □ Lower Back
- □ Knees
- □ Hands
- □ Calves
- □ Arms
- □ Feet
- □ Elbows
- □ Shoulders
- □ Other_____

**EYES/EAR/NOSE/THROAT/RESPIRATORY**

- □ Blurred or failing vision
- □ Difficulty breathing
- □ Earache
- □ Enlarged glands
- □ Eye pain
- □ Frequent colds
- □ Hoarseness
- □ Gum trouble
- □ Nose bleeds
- □ Loss of hearing
- □ Persistent cough
- □ Phlegm *color*_____
- □ Ringing in ears
- □ Sinus problems

**CARDIOVASCULAR**

- □ Chest pain
- □ Pain over heart
- □ Poor circulation
- □ Previous heart attack
- □ Rapid/irregular heart beat
- □ Swelling of ankles

**SKIN**

- □ Boils
- □ Bruise easily
- □ Dry skin
- □ Itching/rash
- □ Sensitive skin
- □ Sore won't heal
- □ Unusual sweating

**GASTROINTESTINAL**

- □ Belching,
- □ Gas
- □ Bloating
- □ Colon trouble
- □ Constipation
- □ Diarrhea
- □ Difficulty swallowing
- □ Excessive hunger
- □ Gall bladder trouble
- □ Hemorrhoids (piles)
- □ Indigestion
- □ Nausea
- □ Pain over stomach
- □ Abdominal Pain
- □ Poor appetite
- □ Vomiting

**GENITOURINARY**

- □ Blood/pus in urine
- □ Frequent or urgent urination
- □ Inability to control urine
- □ Urinary tract infection
- □ Kidney infection/stones
- □ Night Urination. # times_____

- □ Erection difficulties
- □ Penis discharge
- □ Prostate trouble

**Age at Menses _____**

**Length of Cycle (eg 28 days)_____**

**Duration of Cycle (eg 3-5 days)_____**

**Age at Menopause_____**

**# Pregnancies _____ # Births _____**

- □ Vaginal Discharge
- □ Hot Flashes
- □ Vaginal Discomfort

**Even if you are in menopause, answer the questions about how your cycle was.**

- □ Excessive menstrual flow
- □ Menstrual pain
- □ Clots
- □ Irregular cycle
- □ PMS

Could you be pregnant?_____

## SIGNATURE

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

Signature_____ Date _____

# COMMUNITY ACUPUNCTURE ALBUQUERQUE

## Informed Consent, Cancellation and Privacy Policies

I am here for evaluation by the Doctors of Oriental Medicine (DOM) at Community Acupuncture Albuquerque. I understand that the DOMs will utilize medical history plus physical examination to evaluate me. The DOMs may discuss treatment options and course of treatment with me.

The DOMs may carry out the following treatments in this office: primarily acupuncture, but sometimes - moxibustion (heating of acupuncture points), electrical stimulation, therapeutic exercise, massage, Tui Na (oriental medical manipulation of the spine or other joints), drawing a few drops of blood, nutritional advice, the prescription of herbs, supplements, and other natural medicines, lifestyle advice, or other treatments.

I understand that even naturally oriented procedures do carry some amount of risk. Needles are capable of causing bleeding, bruising, or extremely rarely lung or organ injury or infection. Adverse events are minimized when the clinician is properly trained. All needles used are single use only and pre-sterilized minimizing any risk of infection.

I accept that at times acupuncture by the doctors will intentionally generate a local or spreading tingling, aching or other strong sensation. Manipulation, stretching, or exercise can result in some new stiffness or pain. Heat treatment of acupuncture points may, very rarely, leave a tiny burn. Cupping, scraping, bleeding or plum blossom hammer are therapeutic modalities that intentionally cause redness, bleeding or bruising, but I can refuse these modalities at any time. I know that herbs and supplements may cause strong allergic or other reactions, even though these reactions are very rare. I will always retain the right to accept or reject any diagnostic procedure or any treatment, before or during any procedure.

I understand that in a community setting, other patients may overhear my conversation with the DOM and so will ask to discuss in private any issue that I have privacy concerns about. The doctors follow all confidentiality and privacy requirements of the medical professions. I will not disclose anything that I overhear in the course of anyone else's treatment. I also understand that although licensed as primary care practitioners in NM, the DOMs at Community Acupuncture Albuquerque are not providing primary care and I will take care of serious health concerns with my primary care provider.

I understand that no health care provider can ever guarantee results and that the time and number of treatments is not always predictable, but it is my expectation that the doctors will communicate their best estimates to me. I accept the fact that outcomes of treatment vary from no help to full resolution of symptoms, but more commonly, success will be defined as clearly perceivable improvement of my medical problem within a set number of treatments.

Name _____ Signature _____ Date _____

**Financial Policy:** Please contact us up to 2 hours before our clinic starts to cancel. After that time and after the first instance, cancellations will be charged at $15, no-shows at $20, unless there has been an emergency. I acknowledge understanding of the cancellation/no-show policy. Please note that we do not provide diagnostic or treatment codes which may be a requirement for your insurance company and we do not bill insurance companies directly but will provide a receipt.

Signature _____ Date _____

I have received a copy of the Notice of Privacy Practices and the Practices Regarding Disclosure of Patient Health Information. I understand my health information will be used and disclosed consistent with these Notices.

Signature _____ Date _____

# COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

***To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided)***

Check or **Initial Below**

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. _____
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. _____
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. _____
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:

  | | | |
  |---|---|---|
  | *Fever | *Dry Cough | *Sore Throat |
  | *Shortness of Breath | *Runny Nose | *Loss of Taste or Smell |
  | *New abdominal pain or diarrhea | *New fatigue | |

  _____
- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. _____
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____
- I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

| Patient | | Parent / Guardian | | Witness | |
|---|---|---|---|---|---|
| Signature: | _____ | Signature | _____ | Signature | _____ |
| Name | _____ | Name | _____ | Name: | _____ |
| Date | _____ | Date | _____ | Date: | _____ |

# COMMUNITY ACUPUNCTURE ALBUQUERQUE

## Notice of Privacy Practices

***This notice, and the accompanying Practices Regarding Disclosure of Patient Health Information, describe how health information about you may be used and disclosed, and how you can get access to your health information. Please review this information carefully.***

***Understanding your health record:*** A record is made each time you come for an Oriental medicine visit. Your symptoms, the practitioner's judgments, and a plan of treatment are recorded. This record serves as a basis for planning your care and treatment at future visits, and also serves as a means of communication among other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will assist you to ensure it is accurate and make informed decisions about who, what, when, where, and why others may be allowed access to your health information.

***Understanding your health information rights:*** Your health record is the physical property of Community Acupuncture Albuquerque, but the content is about you, and therefore belongs to you. You have the right to review or obtain a paper copy of your health record, and to request that appropriate amendments be made to your health record. You have the right to request restrictions on certain uses and disclosures of your information, to authorize disclosure of the record to others, and be given an account of those disclosures. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information. Should we need to contact you, you have the right to request communication by alternate means or to alternate locations.

***Our responsibilities:*** Community Acupuncture Albuquerque is required to maintain the privacy of your health information and to provide you with this notice of privacy practices. We are required to follow the terms of this notice and to notify you if we are unable to grant your request to disclose or restrict disclosure of your health information to others. Community Acupuncture Albuquerque reserves the right to change these practices and promises to make a good faith effort to notify you of any changes. Other than for the reasons described in this notice, we agree not to use or disclose your health information without your authorization.

***TO REPORT A PROBLEM,*** If you believe your privacy rights have been violated, you have the right to file a complaint with the NM Board of Acupuncture and Oriental Medicine and/or with the U.S. Secretary of Health and Human Services with no fear of retaliation by this office.

# COMMUNITY ACUPUNCTURE ALBUQUERQUE
## Practices Regarding Disclosure of Patient Health Information

***Your health information will be routinely used for treatment, and quality-monitoring, and your consent, or the opportunity to agree or object, is not required in these instances:***

- **Treatment** – Information obtained by your practitioner will be entered in your record and used to plan the course of treatment. Your health information may be shared with others involved in your care or providing consultation about your treatment. Your practitioner's own expectations and those of others involved in your care may also be recorded.
- **Quality Monitoring –** The staff in this office will use your health information to assess the care you received and compare your treatment outcome to others. Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide.

***In addition, the following disclosures are required by law and do not require your consent:***

- **Food and Drug Administration (FDA) –** This office is required by law to disclose health information to the FDA related to any adverse effects of food, supplements, products, and product defects for surveillance to enable product recalls, repairs, or replacements.
- **Worker's Compensation –** This office will release information to the extent authorized by law in matters of worker's compensation.
- **Public Health –** This office is required by law to disclose health information to public health and/or legal authorities charged with tracking reports of birth and morbidity. This office is further required by law to report communicable disease, injury, or disability.
- **Law Enforcement –** (1) Your health information will be disclosed in response to a valid subpoena for law enforcement purposes, as required under state or federal law. (2) In the event that a staff member or business associate of this office believes in good faith that one or more patients, workers, or the general public are endangered due to suspected unlawful conduct of a practitioner or violations of professional or clinical standards, provisions of federal law permit the disclosure of your health information to appropriate health oversight agencies, public health authorities, or attorneys.

***It is the Clinic's practice to consider the following as routine uses and disclosures for which specific authorization will not be requested.*** You have the right to request restrictions on these uses. Otherwise, the Clinic will request your authorization whenever disclosure of personal health information is necessary to parties other than those referenced here.

- **Business Associates –** Some or all of your health information may be subject to disclosure through contracts for services to assist this clinic in providing health care. To protect your health information, we require these Business Associates to follow the same standards held by this office through terms detailed in a written agreement.
- **Communications with Family –** Using best judgment, a family member, close personal friend identified by you, personal representative, or other persons responsible for your care may be notified or given information about your care to assist them in enhancing your well-being or to confirm your whereabouts.