

South Austin Community Acupuncture

321 W. BEN WHITE BLVD • AUSTIN, TEXAS 78704 • (512)707-8330

Orientation to the Clinic

Welcome!

At South Austin Community Acupuncture we offer **treatment in a group setting with an affordable sliding scale fee structure**. We do this because we want you to be able to get acupuncture as often or for as long as you need to get the best results.

Acupuncture tends to work best with some kind of course of treatment.

For acute problems, a series of back to back treatments is often best. For chronic problems, treatment over an extended period of time may be most appropriate. We are here to guide you in getting the most from the services we offer.

To help everyone have the best experience, please follow the important points below.

Consideration of others:

- Cell phones are not allowed in the treatment rooms. Please lock your cell phone in your car or turn it off and check it with the front desk.
- Please be clean when coming for acupuncture. You will be taking your shoes off, so please have clean feet. We're always glad to see you, but would prefer others not have to smell you!
- Do not wear lotions, oils, cologne, perfume, or other scents. Some people are sensitive to smells. Oils and lotions also make needling difficult and mess up our sheets.
- Please enter and exit the group treatment room quietly, and speak softly when talking in the group room. Acupuncture is usually very relaxing, and people often fall asleep.

Responsibility for yourself:

- On your first visit, plan to be at the clinic for about 90 minutes. Follow up treatments may not take as long. While a treatment usually lasts about an hour, we'll leave you as long as you look like you're resting soundly. Please let us know if you are ready to go, or if you want to be out by a certain time.
- Sometimes people snore in the group room. Feel free to bring earplugs if you need to.
- Eat a little something before your treatment. Acupuncture is not recommended on an empty stomach.
- Wear loose, comfortable clothing so we can access just above your elbows and knees easily.

I have read and understand the above:

Signature

Date

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Getting Acupuncture in Texas

In Texas, Licensed Acupuncturists are allowed to treat the following conditions without any prior evaluation or referral requirements. If you are coming for one of these things, indicate this with a checkmark and **skip the rest of this page.**

- Chronic pain
- Smoking addiction
- Substance abuse
- Alcoholism
- Weight loss

If you are coming for anything else, please fill out the following state prescribed form below:

Form to be Completed by Patient, Notifying the Acupuncturist of Whether He/She
Has Been Evaluated by a Physician, and Other Information.

(Pursuant to the requirements of 22 TAC §183.7 of the Texas State Board of Acupuncture Examiners' rules (relating to Scope of Practice and Tex. Occ. Code Ann., §205.351, governing the practice of acupuncture.)

I (patient's name) _____, am notifying South Austin Community Acupuncture of the following:

Yes No I have been evaluated by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

_____ (initials of patient) Date: _____

or

Yes No I have received a referral from my chiropractor within the last 30 days for acupuncture.

After being referred by a chiropractor, if after two months or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice whether to follow this advice.

Signature _____ Date _____

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Clinic payment policies

Community acupuncture in community *supported* acupuncture. We do not receive any grants or other funding to do what we do, and we are only able to do what we do with your support.

South Austin Community Acupuncture operates on a sliding scale. Using your income as a guide, you pick how much you pay between \$20 and \$40 per treatment.

We do not verify income, but do ask that you pay fairly.

Select how much you pay -----▼

If your annual income is:	We suggest you pay:	CHECK ONE
< \$20,000	\$20	<input type="checkbox"/>
> \$20,000 - \$25,000	\$25	<input type="checkbox"/>
> \$25,000 - \$30,000	\$30	<input type="checkbox"/>
> \$30,000 - \$40,000	\$35	<input type="checkbox"/>
> \$40,000	\$40	<input type="checkbox"/>

There is an additional \$10 New Patient fee with your first appointment.

Payment is due at time of service.

Cancellation / No show policy:

Please be considerate. When an appointment is missed or we don't receive adequate notification that you won't be making your appointment, chances are you have kept someone else from getting acupuncture at that time.

- Appointments must be canceled the day before during our business hours.
- You will be charged **for your appointment in full** if you do not show up, or do not cancel the day before.
- Please call to cancel even if you made the appointment online. Do not email us about appointments or cancellations.

I have read and agree to the above:

Signature of patient or guardian

Date

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Patient Information

Date ____ / ____ / ____	Phone: _____
Name: _____	Email: _____
Address: _____	In case of emergency notify: _____
City / State / Zip: _____	Relation: _____ Phone: _____
Age: ____ Date of Birth ____ / ____ / ____	Patient's Representative: _____
Living situation : Live w/other(s) Live alone Single	(if under 18 or otherwise requiring guardianship)
Married Separated Divorced Widowed	Relation: _____
Occupation: _____	
Employer: _____	

Your doctor or other primary care provider: _____

Have you tried acupuncture before? Yes No

How did you find us?

YOUR HEALTH CONCERNS: Why are you coming for treatment?

List any hospitalizations, surgeries, major injuries, or trauma: What and when?

Current medications and supplements:

<p>Check all that apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> epilepsy/seizures <input type="checkbox"/> Hepatitis A/B/C <input type="checkbox"/> HIV+ <input type="checkbox"/> bleeding disorder or hemorrhage <input type="checkbox"/> taking blood thinners 	<ul style="list-style-type: none"> <input type="checkbox"/> pacemaker <input type="checkbox"/> fainting <input type="checkbox"/> diabetes <input type="checkbox"/> mental illness <input type="checkbox"/> addiction <input type="checkbox"/> other _____
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<p>LIFESTYLE:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Exercise regularly <input type="checkbox"/> Eat much fried food <input type="checkbox"/> Eat much meat <input type="checkbox"/> Eat a lot of sweets / carbs <input type="checkbox"/> Vegetarian / vegan <input type="checkbox"/> Drink alcohol <input type="checkbox"/> Drink coffee <input type="checkbox"/> Smoke cigarettes <input type="checkbox"/> Use drugs <p>SLEEP:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Not rested upon waking <input type="checkbox"/> Trouble falling / staying asleep <input type="checkbox"/> Less than 6 – 8 hours <input type="checkbox"/> Insomnia <p>GASTRO-INTESTINAL:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Excessive / low appetite <input type="checkbox"/> Fatigued after meals <input type="checkbox"/> Hypoglycemic <input type="checkbox"/> Indigestion / reflux / heartburn <input type="checkbox"/> Nausea / vomiting <input type="checkbox"/> Gas / bloating <input type="checkbox"/> Stomach ache / abdominal pain <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea / loose stools <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Gallstones <p>CARDIO-VASCULAR:</p> <ul style="list-style-type: none"> <input type="checkbox"/> High / low blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Palpitations <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid / irregular heartbeat <p>HEAD / FACE:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Headaches / migraines <input type="checkbox"/> TMJ / jaw pain 	<p>TEMPERATURE / PERSPIRATION:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Hot / Cold body sensation overall <input type="checkbox"/> Aversion to heat or cold <input type="checkbox"/> Cold hands / feet <input type="checkbox"/> Hot flashes / night sweats <input type="checkbox"/> Spontaneous sweating <input type="checkbox"/> Sweaty palms / feet <p>EYES / ENT / RESPIRATORY:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Frequent colds / sinus infections <input type="checkbox"/> Sinus problems <input type="checkbox"/> Chronic / seasonal allergies <input type="checkbox"/> Environmental sensitivity <input type="checkbox"/> Cough <input type="checkbox"/> Asthma / wheezing <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Sore throat <input type="checkbox"/> Enlarged glands <input type="checkbox"/> Ear ache <input type="checkbox"/> Impaired hearing / hearing loss <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Dizziness <input type="checkbox"/> Red / inflamed / itchy eyes <input type="checkbox"/> Teary / dry eyes <input type="checkbox"/> Gum problems <input type="checkbox"/> Nose bleeds <p>DERMATOLOGICAL:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Rash / itching / hives <input type="checkbox"/> Acne / boils <input type="checkbox"/> Hair falling out <input type="checkbox"/> Weak / brittle nails <input type="checkbox"/> Slow wound healing <p>GENITO-URINARY:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Frequent urination <input type="checkbox"/> Poor bladder control <input type="checkbox"/> Burning / pain on urination <input type="checkbox"/> Frequent urinary tract infections <input type="checkbox"/> Kidney stones 	<p>EMOTIONAL / PSYCHOLOGICAL:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Mood swings <input type="checkbox"/> Irritability <input type="checkbox"/> Difficulty concentrating <input type="checkbox"/> Worry <input type="checkbox"/> Feel sad a lot <input type="checkbox"/> Cry uncontrollably <input type="checkbox"/> Much fear / terrors <input type="checkbox"/> History of abuse <input type="checkbox"/> Considered or attempted suicide <p>FEMALE ONLY:</p> <ul style="list-style-type: none"> <input type="checkbox"/> May be pregnant <input type="checkbox"/> Irregular cycle <input type="checkbox"/> Painful periods <input type="checkbox"/> Heavy / scant periods <input type="checkbox"/> Chronic vaginal infections <input type="checkbox"/> Abnormal pap <input type="checkbox"/> Endometriosis <input type="checkbox"/> Ovarian cysts <input type="checkbox"/> Uterine fibroids <input type="checkbox"/> Partial / Total Hysterectomy <p>Number of: Pregnancies - Abortions - Miscarriages -</p> <p>Number of Births: Vaginal - Cesarean -</p> <p>Cycle is ____ days. Period lasts ____ days.</p> <p>MALE ONLY:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Premature ejaculation <input type="checkbox"/> Penis discharge <input type="checkbox"/> Prostate problems
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INFORMED CONSENT TO TREATMENT

At South Austin Community Acupuncture we principally practice acupuncture (sometimes with electrical stimulation), cupping, and Chinese herbal medicine. We may also recommend dietary supplements or make dietary recommendations, suggest exercises, or do minimal bodywork. We generally don't do gua sha (scraping) or moxabustion, although we may provide moxabustion and instructions for home use.

I, the undersigned, hereby request and consent to treatment by acupuncture and/or other procedures within the scope of the practice of acupuncture. I am hereby informed that the treatment methods are all generally safe but that there may be some side effects or risks, as follows:

Acupuncture may potentially cause temporary bruising, swelling, bleeding, numbness and tingling, or soreness at the site of needling. Highly unlikely risks of acupuncture include lung puncture (pneumothorax), nerve damage, organ puncture, and infection - although South Austin Community Acupuncture uses only sterile, disposable needles and maintains a clean and safe environment. Acupuncture can cause aggravation of symptoms existing prior to treatment and appearance of new symptoms.

Common side effect of cupping and gua sha are temporary bruising and redness lasting a few days. Cupping can also cause blistering of the skin in some instances.

The herbal and nutritional supplements (which may be from plant, animal, or mineral sources) recommended to me by my practitioner are generally safe in the traditionally recommended doses. Possible side effects of herbs include nausea, gas, stomach ache, diarrhea, and headache. Unusual side effects of plant herbs include vomiting, rashes, hives, and tingling of the tongue. I understand I must stop taking any herbs and notify my acupuncturist if I experience any discomfort or adverse reaction.

I understand that I have the right to refuse any part of the treatment. I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose, although I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments. I intend this form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment with South Austin Community Acupuncture.

I will notify my acupuncturist should I become pregnant or if I am in the process of trying to get pregnant as certain acupuncture points and herbs may be contraindicated during pregnancy.

Signature of patient or guardian

Date