



Welcome

We're so happy to have you as part of our clinic community.
These are our basic office policies.

THESE ARE OUR POLICES. PLASE TAKE THE TIME TO READ THEM TO HELP OUR CLINIC FLOW AS SMOOTHLY AS POSSIBLE.

FEE FOR TREATMENT

\$40-\$80 sliding scale for treatment. You decide what you can afford. What you pay does not effect the treatment you receive. We accept cash, check, most credit cards, as well as HSA/FSA cards. We prefer cash and check, as we incur a 3% charge for every credit card transaction
\$15 additional fee for first time treatments

ARRIVE AT LEAST 10 MINUTES EARLY FOR FOLLOW UP VISITS

Please come early enough to check in, reschedule, pay, use the bathroom, etc...so that you can be settled into your treatment chair by your appointment time. **IF YOU ARE MORE THAN 10 MINUTES LATE TO YOUR APPOINTMENT,** we may need to reschedule

CANCELATION AND NO SHOW

Please give at least 24 hours notice to change, or cancel your appointment.
Failure to do so, or a no show will result in a **\$20 fee.**

CONTAGIOUS DISEASE

If you are experiencing any flu like symptoms or symptoms please reschedule. Late cancelations or reschedules for this reason will not incur late fee.

REFRAIN FROM WEARING SCENTED PRODUCTS TO YOUR TREATMENT

SILENCE or TURN OFF your cell phone prior to coming in

WEAR A COVERING over your nose and mouth while you are at the clinic

Please write your name, date, and sign to indicate you have read and agree to our office policies

Name:_____ Signature:_____ Date:_____



Chico Community Acupuncture Informed Consent

Acupuncture is overwhelmingly safe, and people typically find it relaxing and energizing, and that they benefit from treatment.

That being said, we want you to be aware of some of the potential risks of treatment including bruising, bleeding at the insertion site, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible side effect. Infection is uncommon since we use sterile, single use, disposable needles and we maintain a clean and safe environment. Burns are a potential risk of moxibustion (rarely done in this clinic). Some possible side effects of taking herbs prescribed are nausea, gas, stomach ache, vomiting, headache, diarrhea, rashes, hives, and tingling tongue.

Please let us know of any concerns or side effects you may experience.

If you are pregnant (planning on becoming pregnant), have a bleeding disorder, pacemaker, high blood pressure, local infection, have been prescribed blood thinners like Coumadin, or another condition that may be critical for us to know about, we can still treat you but please make us aware of your condition.

By signing below, you indicate that you consent to treatment and understand the potential risks.

Name _____ **Date** _____

Signature _____

If patient is under 18 please also complete the following:

I _____, authorize Chico Community Acupuncture to treat
(child's name) _____ who is my (relationship) _____

Thank you and we look forward to working with you!



Signature New Patient Intake

Patient Name _____

Today's Date _____

Date of Birth ____/____/____ Age _____ Sex _____

Mailing Address _____ City _____ State _____ Zip _____

Phone (____) _____ Alt. Phone (____) _____

Email _____

Circle All That Apply: Unemployed FT Parent/Caregiver Retired FT Student Employed

If Employed: Occupation _____ Employer _____

Do you have a primary care provider? YES NO If yes, name _____

Emergency Contact:

Name _____ Phone _____ relationship _____

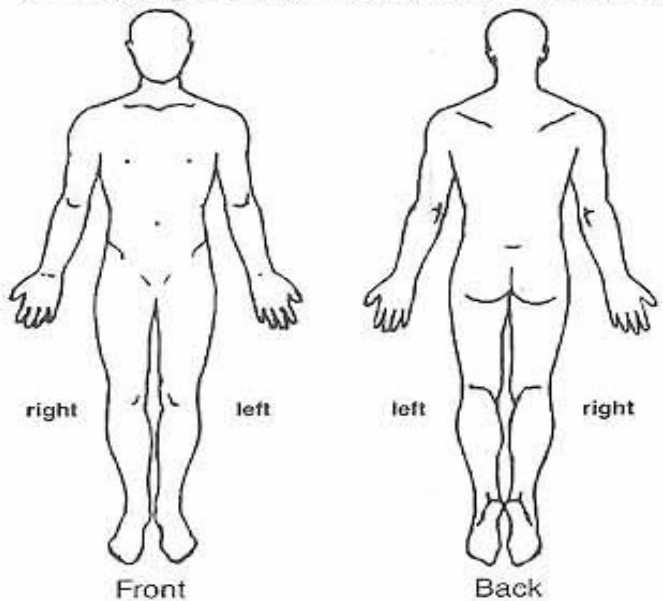
How did you hear about us? _____ Have you had acupuncture before? Yes / No

Would you like to receive updates from our clinic (including specials)? Yes / No

What are your primary reasons for getting treated today?

How long has it been going on? _____

How bad is it on a scale of 1-10 (10 being the worst)?



Mark areas of concern

Patient Name _____ Date _____

Mark any concerns you would like to address with acupuncture.

<p>Digestion Diarrhea Constipation Nausea / Vomiting Appetite issues Pain Heartburn Hemorrhoids</p> <p>Cardiovascular High / Low Blood Pressure Anemia Floaters in the eyes Heart disease Dizziness Cold hands and feet Palpitations Pacemaker</p> <p>Mental / Emotional Depression Anxiety Stress Grief Anger Worry Brain Fog</p>	<p>Other Concerns Frequent Thirst Fatigue Frequent Colds Poor Sleep Headaches Allergies Ear Ringing Hypothyroid Hyperthyroid Diabetes Hepatitis Arthritis Cancer HIV Consumption of Caffeine, Sugar, Alcohol, Nicotine, or any other substance</p> <p>Reproductive Health Date of last menstrual period _____ Fertility PMS Hot Flashes Night Sweats Irregular or painful menses Enlarged Prostate Erectile dysfunction</p>	<p>Genito-Urinary Infection Frequent urination Inability to hold urine</p> <p>Surgeries, hospitalizations, significant illnesses, on- going concerns, with dates _____ _____ _____ _____ _____ _____ _____</p> <p>medications, vitamins, or supplements _____ _____ _____ _____ _____</p>
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Is there anything else you would like us to know about your goals for treatment?



Payment Policies

Our goal at Chico Community Acupuncture INC (CCA) is for you to get as much acupuncture as you need to meet your specific health goals. We are a non-profit organization that runs exclusively on fees collected for services.

\$40-80 sliding scale fee for each acupuncture, cupping, and herbal consultation appointment.

Additional \$15 initial patient fee for new patients.

- * What you pay does not effect the treatment you receive
- * No income verification required.
- * Payment due at the time of service

Initial: _____

Financial Accommodation

If you are unable to pay our regular sliding scale, you may complete the financial accommodation request below and come up with a financial agreement that works for you and Chico Community acupuncture, with respect to your treatment plan.

I am requesting a financial accommodation. At this time, I am unable to pay the standard sliding scale due to my personal financial logistics. In the event my situation changes, I will update the clinic and come up with a new plan, or start paying the standard sliding scale. I understand the agreement is determined on a month to month basis and the clinic may not renew the agreement.

Name: _____ Signature: _____ Date: _____