

LOUISVILLE COMMUNITY ACUPUNCTURE

909 Barret Ave 40204 – 502.589.6860

Welcome to Louisville Community Acupuncture!

About Community Acupuncture

Traditionally we have treated clients in a group setting using recliners, hence the “community.” With the current state of the corona virus creating the need to maintain distance between individuals to prevent spread, we are modifying our approach so that we can continue to provide accessible acupuncture.

Initially we will be using our private rooms and conducting 45 minute treatments. This unfortunately has caused us to increase our rates. Instead of a sliding scale of \$20-\$40, we **now are charging \$30-\$50**. It is still a pick what you want to pay option.

We hope to expand back to our community room in time so that we can bring our sliding scale back down and provide more acupuncture. But we are going to do that in time as we gather more information on how the spread of the virus is proceeding in general and how environments like ours specifically need to operate.

That being said, our approach still emphasizes community rather than individuality. Louisville Community Acupuncture (LCA) is one of many community acupuncture clinics established in the country who are members of the People’s Organization of Community Acupuncture (POCA). To be a part of an even bigger community, learn more about the cooperative and to find POCA member clinics near your friends and family, visit www.pocacoop.com. Collectively, POCA clinics provide over one million acupuncture treatments annually!

There are plenty of theories that circulate about acupuncture but all we can say is they are still being investigated. We have a strong view that people should be able to try it and allow themselves to use it to improve their health. Our goal is to provide a setting where most people can afford a series of treatments in order to get good results from our treatment plans.

General Acupuncture Treatment Tips

- Please only enter the building at your appointment time as we are not using our waiting room
- Wear a mask while in the building—we have cloth ones available if you did not bring one.
- Turn those cell phones off while in the clinic.
- Anticipate being here for 45-60 minutes.
- Avoid wearing scented products as many people come into our space through the day.
- Don’t come starving.
- Wear clothing that can let the acupuncturists get to your elbows and knees
- Be considerate of the space. It is for everyone who enters, not just one person.

Our Sliding Scale Philosophy

The purpose of the sliding scale \$30 - \$50 per visit (and a \$10 new patient paperwork fee) is to make sure you are receiving affordable care enough to get good results. We do not ask for proof of income. Because of the sliding scale, we cannot do insurance billing but if you have insurance, we will be happy to give you a payment receipt that you can submit.

Please bring a friend and spread the word of health and community. By supporting this clinic, you are participating in making the benefits of acupuncture accessible to more people.

We are happy you are here!!!

LCA Staff

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Patient Registration and Health History

Patient Information	Contact Information
Today's Date ____ / ____ / ____	Home Phone: _____
Name: _____	Work Phone: _____
Address: _____	Cell Phone: _____
City, State, Zip _____	Email: _____
Age: _____ Date of Birth ____ / ____ / ____	In case of emergency notify: _____
Height: _____ Weight: _____	Relation: _____ Phone: _____
Gender: _____	Patient's Representative: _____
Relationship Status: Live w/other(s) Live alone Single Married Separated Divorced Widowed	(if under 18 or otherwise requiring guardianship)
Occupation: _____	Relation: _____
Employer: _____	

Who is 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? DOES ANYTHING MAKE THIS CONDITION BETTER OR WORSE?

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

CURRENT MEDICATIONS AND SUPPLEMENTS:

FAMILY HISTORY: INDICATE ANY RELATIVES AFFECTED BY THE FOLLOWING:

Epilepsy/Seizures	HIV+	Bronchitis	Addiction
Anemia	Hepatitis A/B/C	Tuberculosis	Other _____
Bleeding or hemorrhage	Thyroid disorder	Chicken Pox	
Heart disease	Asthma	Cancer	
Diabetes	Pneumonia	Emotional imbalance	

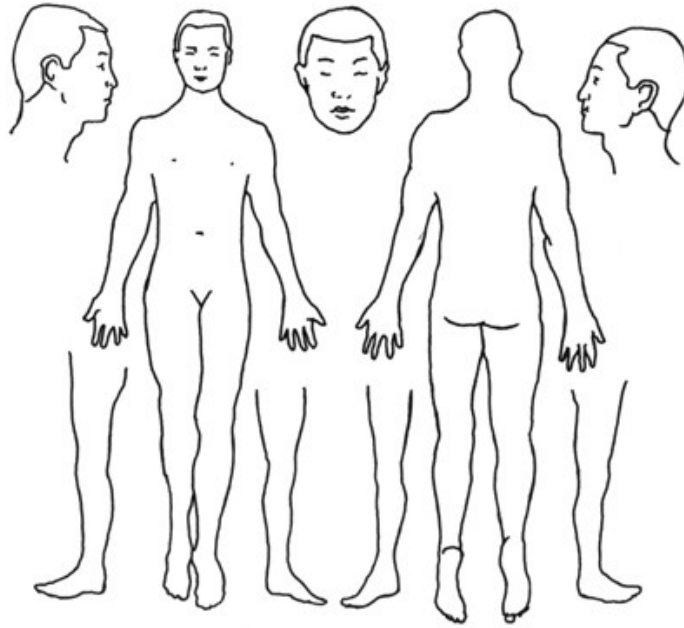
YOUR HISTORY: DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING:

Epilepsy/Seizures	HIV+	Bronchitis	Addiction
Anemia	Hepatitis A/B/C	Tuberculosis	Other _____
Bleeding or hemorrhage	Thyroid disorder	Chicken Pox	
Heart disease	Asthma	Cancer	
Diabetes	Pneumonia	Emotional imbalance	

PATIENT PROFILE: Please check any that apply to you

<p>LIFESTYLE:</p> <input type="checkbox"/> EXERCISE REGULARLY <input type="checkbox"/> EAT MUCH FRIED FOODS <input type="checkbox"/> EAT MUCH MEAT <input type="checkbox"/> EAT A LOT OF SWEETS <input type="checkbox"/> VEGETARIAN <input type="checkbox"/> DRINK ALCOHOL <input type="checkbox"/> DRINK COFFEE <input type="checkbox"/> SMOKE CIGARETTES <input type="checkbox"/> USE DRUGS <p>GASTRO-INTESTINAL:</p> <input type="checkbox"/> EXCESSIVE APPETITE <input type="checkbox"/> LOW APPETITE <input type="checkbox"/> FATIGUED AFTER MEALS <input type="checkbox"/> HYPOGLYCEMIA <input type="checkbox"/> INDIGESTION / REFLUX / HEARTBURN <input type="checkbox"/> NAUSEA / VOMITING <input type="checkbox"/> GAS / BLOATING <input type="checkbox"/> ABDOMINAL PAIN / STOMACH ACHE <input type="checkbox"/> STOMACH ULCER <input type="checkbox"/> GALLSTONES <input type="checkbox"/> EATING DISORDER <input type="checkbox"/> LESS THAN 1 BM A DAY / CONSTIPATION <input type="checkbox"/> DIARRHEA / LOOSE STOOL <input type="checkbox"/> HEMORRHOIDS <input type="checkbox"/> BLOOD IN STOOL <input type="checkbox"/> IBS <p>GENITO-URINARY:</p> <input type="checkbox"/> FREQUENT URINATION <input type="checkbox"/> POOR BLADDER CONTROL <input type="checkbox"/> BURNING / PAIN ON URINATION <input type="checkbox"/> DARK URINE <input type="checkbox"/> CLOUDY URINE <input type="checkbox"/> FREQUENT URINARY TRACT INFECTION <input type="checkbox"/> KIDNEY STONES <p>CARDIO-VASCULAR:</p> <input type="checkbox"/> HIGH BLOOD PRESSURE <input type="checkbox"/> HIGH CHOLESTEROL <input type="checkbox"/> PALPITATIONS / IRREGULAR HEARTBEAT	<p>TEMPERATURE / PERSPIRATION:</p> <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 <input type="checkbox"/> NIGHT SWEATS <input type="checkbox"/> SPONTANEOUS SWEATING <input type="checkbox"/> SWEATY PALMS / FEET <p>SKIN:</p> <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>HEAD/EARS/EYES/NOSE/THROAT:</p> <input type="checkbox"/> HEADACHES / MIGRAINES <input type="checkbox"/> JAW PAIN / TMJ <p>-----</p> <input type="checkbox"/> IMPAIRED HEARING / HEARING LOSS <input type="checkbox"/> RINGING IN EARS <input type="checkbox"/> DIZZINESS <input type="checkbox"/> EARACHE <p>-----</p> <input type="checkbox"/> SPOTS IN FRONT OF EYES <input type="checkbox"/> POOR NIGHT VISION <input type="checkbox"/> TEARING OR DRYNESS <input type="checkbox"/> RED / INFLAMED / ITCHY EYES <p>-----</p> <input type="checkbox"/> SINUS PROBLEMS <input type="checkbox"/> NOSE BLEEDS <input type="checkbox"/> LOSS OF SMELL <p>-----</p> <input type="checkbox"/> MOUTH ULCERS / SORES ON TONGUE <input type="checkbox"/> BAD BREATH <input type="checkbox"/> BLEEDING GUMS <input type="checkbox"/> RECURRENT SORE THROAT <p>RESPIRATORY:</p> <input type="checkbox"/> FREQUENT COLDS/SINUS INFECTIONS <input type="checkbox"/> CHRONIC ALLERGIES <input type="checkbox"/> ENVIRONMENTAL SENSITIVITY	<p>SLEEP:</p> <input type="checkbox"/> LESS THAN 6-8 HOURS PER NIGHT <input type="checkbox"/> NOT RESTED UPON WAKING <input type="checkbox"/> DIFFICULTY FALLING / STAYING ASLEEP <input type="checkbox"/> INSOMNIA <p>EMOTIONAL/PSYCHOLOGICAL:</p> <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>GYNECOLOGICAL:</p> <input type="checkbox"/> MAY BE PREGNANT <input type="checkbox"/> PMS <input type="checkbox"/> PAINFUL PERIODS <input type="checkbox"/> HEAVY PERIODS <input type="checkbox"/> CLOTS WITH PERIOD <input type="checkbox"/> IRREGULAR CYCLE <input type="checkbox"/> BLEEDING BETWEEN PERIODS <input type="checkbox"/> PARTIAL / TOTAL HYSTERECTOMY <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 <p>PERIOD LASTS _____ DAYS _____ DAYS BETWEEN PERIOD AGE AT MENOPAUSE _____</p> <p>NUMBER OF: PREGNANCIES _____ ABORTIONS _____ MISCARRIAGES _____</p> <p>BIRTHS: ____ VAGINAL ____ CESAREAN</p>
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Indicate painful or distress areas:



Are there any other issues you want to discuss with us?

Please circle any of the following conditions you have or suspect you might have

- Hypertension and cardiac conditions
- Acute, severe abdominal pain
- Undiagnosed neurological changes
- Unexplained weight loss/gain in excess of 15% your body weight in less than a 3 month period
- Suspected fracture or dislocation
- Suspected systemic infection(s)
- Suspected hemorrhagic disorder
- Acute respiratory distress without a previous history
- Pregnancy
- Diabetes

Are you currently under the care of a physician for this or any of these conditions?

If YES, please list the name and contact information of the treating physician

I am aware that I should not replace treatment from a physician with acupuncture, or any other holistic modality, for the above conditions

Signature: _____

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INFORMED CONSENT TO TREATMENT

I, the undersigned, hereby request and consent to treatment by acupuncture and/or other procedures within the scope of the practice of acupuncture. Methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, herbal therapy, bodywork, and nutritional counseling.

I am hereby informed that the aforementioned 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 Louisville Community Acupuncture uses only sterile, disposable needles and maintains a clean and safe environment.

Potential risks of moxibustion include blistering, burns, and scarring. 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 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 will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant as certain acupuncture points and herbs are contraindicated during pregnancy and could induce miscarriage.

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 understand that my acupuncturist may review my medical records and lab reports, but all my records will be kept confidential. My health information will be handled in accordance with the Summary of Privacy Practices document that has been provided to me, and of which I have acknowledged receipt.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment; payment and healthcare operations received, incurred or carried out at this practice.

Signature

Date

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SUMMARY OF PRIVACY PRACTICES

We don't do anything with your health data without your written consent.

We have a complete NOTICE OF PRIVACY PRACTICES that is available in our office if want to read the complete details.

I. How we may use and share health data about you:

- a) Treatment - To give you medical treatment or other types of health services.
- b) Payment - To bill you or a third party for payment for services provided to you.
- c) Health Care Operations - For our own operations such as quality control, compliance monitoring, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:

- a) To you
- b) As required by federal, state, or local law
- c) If child abuse or neglect is suspected
- d) Public health risks (for public health activities to prevent and control spread of disease)
- e) Lawsuits and disputes (in response to a court or administrative order)
- f) Law enforcement (to help law enforcement officials respond to criminal activities)
- g) Coroners, medical examiners and funeral directors
- h) Organ or tissue donation facilities if you are an organ donor
- i) To avert a threat to an individual or to public health safety

III. Disclosures where we have to give you a chance to agree or object:

- a) Patient directories - You can decide what health data, if any, you want to be listed in patient directories.
- b) Persons involved in your care or payment for your care - We may share your health data with a family member, a close friend or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you:

- a) Right to inspect your health record and to receive a copy of your health record upon request
- b) Right to amend information in your health record you believe is inaccurate or incomplete
- c) Right to know to whom we have disclosed your health information
- d) Right to ask for limits on the health information data we give out about you
- e) Right to receive communication from us about your health information in alternate ways
- f) Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have read this SUMMARY OF PRIVACY PRACTICES and understand that I may request the full NOTICE OF PRIVACY PRACTICES document from Louisville Community Acupuncture at any time.

Signature

Date