Welcome to Working Class Acupuncture!

We are delighted that you have decided to try acupuncture with us. Here are some things you should know:

About acupuncture

Acupuncture is very old, and nobody really knows why it works. There are a lot of different theories, but they are all just theories. We believe people should be able to try it and decide for themselves if they want to use it to improve their health. In most cases, people need a series of treatments to get good results. Your acupuncturist will suggest a treatment plan: how often you should come in and when you might expect to see results.

About the community setting

The community acupuncture model makes it affordable to more people. When acupuncture is too expensive, people often don't get enough treatments to get good results. Our goal is to make it possible for you to get as much acupuncture as you want to get.

With community acupuncture, we treat everybody in a shared space, in recliners. You do not need to disrobe. Once you are in a recliner you like we will ask; if you're comfortable removing your shoes and socks, to roll your pants up to your knees, and your sleeves up to your elbows. Most conversations happen at the whisper level because there is usually at least one person resting in the treatment room at any given time. After your acupuncturist puts the needles in, your job is to relax and let them work. You can stay as long as you like; most people stay between 40 minutes to an hour. When you are ready to go, open your eyes and give us a meaningful look when we walk through the treatment room (this happens about every 10 minutes). We'll come over and take your needles out.

Ambient music and white noise machines play in the treatment rooms. If you prefer your own sounds, you are welcome to bring personal listening devices. People do snore sometimes, so if snoring bothers you, you should consider bringing ear plugs or headphones. You are also welcome to bring your own neck pillows or blankets if you prefer them to ours. We won't be offended.

About our business

WCA is a 501c3 nonprofit. We gratefully accept donations, but we depend on patients paying what they can afford for treatments. This means WCA only breaks even financially, while providing as much affordable acupuncture as possible and creating as many living wage jobs for acupuncturists as we can. We rarely receive any grants or government funding to cover the day-to-day expenses; we depend entirely on fees for service. Our acupuncturists are employees, not self-employed independent contractors. If you enjoy your experience, please tell your friends because word of mouth referrals keep us open.

Our payment structure is sliding scale ($25-$45 per visit and a one-time $10 paperwork fee) so you can get enough treatment for it work! Please don't try to pay us too much and then not come in often enough. We would rather you come in more often and pay less–really and truly. If you are having any financial difficulties with your treatment plan, please talk with your acupuncturist.

About the community acupuncture movement

We redesigned the business model for acupuncture so more people could afford it. Many clinics around North America have joined the movement. To learn about People's Organization of Community Acupuncture (POCA) and to find POCA member clinics in other cities, visit www.pocacoop.com and click on the "Clinics" tab.

Working Class Acupuncture / ORCCA Student Clinic
Health History Questionnaire and Registration

Patient Information

Today's date_____/____/_____

Name_____
(first) (middle) (last)

Birth date_____/____/_____ Age _____

Preferred pronoun(s)_____
(optional)

Occupation_____

Company name _____

How did you hear about us? _____

_____

Contact Information

Address_____

City_____State_____Zip_____

Cell phone _____

Work phone _____

Other/home phone_____

Email _____

Another person we may contact if needed:

Name _____

Relationship_____

Cell phone _____

Health History

What are your primary reasons for seeking treatment today?

1 _____

2 _____

3 _____

How is your sleep? _____

_____

How is your digestion? _____

_____

List medications or food supplements you are taking.

_____

_____

List significant and/or chronic illnesses, accidents or surgeries.

_____

_____

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

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

Check any additional areas of concern you have other than your primary reasons for coming:

- ▫ Muscle/Joint/Bone
- ▫ Eyes/Ears/Nose/Throat/Respiratory
- ▫ Skin related issues
- ▫ Genito/Urinary
- ▫ Cardiovascular
- ▫ Gastrointestinal
- ▫ Menstrual related issues
- ▫ Sexual/Reproductive

Are you pregnant? Yes_____ / No_____

Signature

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

Signature_____ **Date**_____

WCA/ORCCA Informed Consent to Treat and PARQ

I consent to receive acupuncture treatment and other procedures within the scope of acupuncture practice (for myself or for the patient named below, for whom I am legally responsible) from acupuncturists at Working Class Acupuncture (WCA) or the student interns and clinical supervisors of the ORCCA Student Clinic. All treatments by student interns are given under direct supervision of clinical supervisors. This treatment may include, but is not limited to: acupuncture, ear seeds and herbs.

I understand that acupuncture involves the insertion of fine needles at specific points on the body. Acupuncture is generally considered to be a very safe method of treatment, but I understand that side effects can occur. Possible side effects of acupuncture include bruising, bleeding, numbness or tingling near the needling sites that may last a few days, dizziness, and fainting. Unusual risks of acupuncture include infection, spontaneous miscarriage, seizures, nerve damage, and organ puncture, including lung puncture (pneumothorax). We use sterile, single-use acupuncture needles and maintain a clean and safe environment.

I understand that these clinics provide acupuncture in a community setting. Common side effects of acupuncture treatment in this setting include deep relaxation, falling asleep, and snoring. I understand that if I need to be woken up at a certain time, I will let my acupuncturist or intern, and clinical supervisor know. I understand that I might be too relaxed to drive immediately after treatment, that if people's snoring bothers me, I need to bring earplugs or headphones and that at times, someone else might be sitting in my favorite recliner. I understand community acupuncture involves actual community with a wide variety of people, and may at times require some flexibility, patience, or understanding from me.

I understand that acupuncture needles are very small; a different practitioner may remove the needles than the one who inserted them; and so I may need to help my acupuncturist or student intern locate all of the needles at the end of my treatment and before I leave the clinic. I understand that these clinics need to treat a high volume of patients in order to keep their prices low, and I am willing to participate in my own treatment process.

I understand that while this form describes major risks of treatment, other side effects and complications may occur. I do not expect the acupuncturist and/or student interns and clinical supervisors to be able to anticipate or explain all possible risks and complications of treatment and that results are not guaranteed. I understand that there are many alternative procedures and methods of treatment to acupuncture, depending on a person's chief complaint and if I am interested in alternative procedures, it is encouraged to consult a primary care provider who can make recommendations based on individual concerns.

I understand that acupuncture is a process, and that results will be best when I receive acupuncture regularly and as frequently as my acupuncturist and/or interns and clinical supervisors recommends. I will ask my acupuncturist and/or interns and clinical supervisors if I have questions about my treatment or about the risks and benefits of acupuncture. I will notify acupuncturist and/or interns and clinical supervisors if I am or become pregnant.

By signing this form, I understand I am a cooperative participant in my treatment at WCA and/or the ORCCA Student Clinic. I have read this information (or had it read to me), and I have had an opportunity to ask questions. By signing below I voluntarily give consent to receive acupuncture as treatment for my present condition and for any future conditions.

_____

Patient Name Patient Signature (or Representative) Date

_____

Acupuncturist/Clinical Supervisor Name Acupuncturist/Clinical Supervisor Signature Date

Patient Responsibilities

1. I understand that my records will be kept confidential and will not be released without my written consent. Clinical and administrative staff may review my records as needed.
2. As a patient, your responsibility is to give at least 24 hours notice to cancel an appointment or to change it to another day. If you don't do this, you will need to pay a fee of $25. The last thing we want is for you to pay $25 to not get acupuncture. So please come in for your appointments and give appropriate notice when you need to cancel. To cancel on short notice, you must call. Please do NOT email us about cancellations.
3. The people who staff the front desk are WCA volunteers. They are giving their time so that WCA and the ORCCA Clinics can continue without having to raise our fees above the sliding scales - $25- $45 at WCA and $10-$20 at ORCCA. It is your responsibility to treat our WCA volunteers with patience and respect even if a volunteer makes a mistake or you need to wait longer than you'd like.
4. I hereby expressly waive and release any and all claims, now known or hereafter known, against WCA and/or ORCCA and its affiliates on account of anything arising outside of the ordinary, as explained, related to my participating in receiving treatment.

_____

Patient Name Patient Signature (or Representative) Date

HIPAA Authorization to Use and Disclose Protected Health Information

1. I hereby authorize WCA/ORCCA to use and/or disclose the protected health information about me described below ("PHI") to Care Oregon or other outside organizations that I have chosen to share with.
2. The PHI that may be used and/or disclosed is: my full name and scheduled appointment information(frequency of treatments or date of treatments.
3. The PHI may be used and/or disclosed for the following purpose: For Care Oregon to track continuity of care provided by WCA/ORCCA.
4. This authorization shall remain in effect until: you cease receiving treatments.
5. The entity receiving health information under this authorization will not receive direct or indirect remuneration in exchange for disclosing the health information.
6. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this form.
7. I understand that, as set forth in the notice of privacy practices, I have the right to revoke this authorization, in writing, at any time, except to the extent that WCA/ ORCCA has acted in reliance upon it, by sending written notification to: my primary care provider or any WCA clinic.
8. I understand that I have the right to refuse to sign this authorization.
9. I understand that PHI used or disclosed pursuant to this authorization may be redisclosed by the recipient and its confidentiality may no longer be protected by federal or state law.

_____

Patient Name Patient Signature (or Representative) Date