

# Welcome to Our Community!

Please take a minute to read this introduction to our clinic and to our community. We are delighted that you are interested in joining us!

## *What is different about Body in Balance Community Acupuncture Center?*

- **We treat in a community setting -**

Most US acupuncturists treat patients on tables in individual cubicles. This is not traditional in Asia, where acupuncture usually occurs in a community setting. In our clinic we primarily use recliners, clustered in groups in a large, quiet, soothing space. Treating patients in a community setting has many benefits: it's easy for friends and family members to come in for treatment together; many patients find it comforting; and a collective energetic field becomes established which actually makes individual treatments more powerful. In some styles of acupuncture, the needles are removed after only a few minutes or after a half hour at most. The style of acupuncture we practice at BIBCAC allows patients to keep their needles in as long as they want, and the "right" amount of time varies from patient to patient. Most people learn after a few treatments when they feel "done"; this can take from twenty minutes to a couple of hours! Many people fall asleep, and wake feeling refreshed.

- **We have a sliding scale -**

Most US acupuncturists also see only one patient per hour and charge \$75 to \$175 per treatment. They tend to spend a long time talking with each patient, going over medical records, asking many questions. We don't. The only way that we at BIBCAC can make acupuncture affordable and still make a living ourselves is to streamline our treatments and see multiple patients in an hour, so we have returned to the traditional approach; instead of asking you lots of questions, we rely on pulse diagnosis to decide how to treat you. This is exactly how acupuncture is practiced traditionally in Asia -- many patients per hour and very little talking.

Because we have a sliding scale, we cannot do insurance billing (that's the insurance companies' rule). If you have insurance that covers acupuncture, we'll be happy to give you a payment receipt, and you can submit it; that's OK with the insurance companies.

## *Our Commitment to You*

We want to make it possible for you to receive acupuncture regularly enough and long enough to get better and stay better. We want our community to be welcoming to all different kinds of people. We want to give you natural healing options at a price you can afford. We will provide a safe environment with skilled practitioners.

## *What We Need From You*

### ◆ **Responsibility**

BIBCAC does not provide primary care medicine! Acupuncture is a wonderful complement to Western medicine, but it is not a substitute for it. If you think you have a problem that is not "garden variety" (meaning, you are worried that you might have a serious infection, a malignant growth, or an injury that won't heal), or if you want someone knowledgeable to go over the details of your medical history with you, you need to see a primary care physician (ND, MD, or DO). We can provide some excellent, affordable referrals, even if you have no insurance coverage. But you cannot expect us to diagnose and treat something really serious. *We can* provide complimentary care for conditions, which require a physician's attention -- for instance, we can treat patients for the side effects of chemotherapy. But we need you to take responsibility for your own health.

BIBCAC is a free-market solution to today's health care crisis, and does not receive grants, state or federal money, or insurance reimbursement. BIBCAC exists because patients pay for their treatments – it a sustainable community business model.

### ◆ Flexibility

The community setting requires some flexibility from you. For instance, many patients have a favorite recliner. When we are busy, someone may be sitting in yours. Some of our patients may bring favorite pillows or blankets from home with them, because they prefer theirs to ours. That's fine with us. Basically, we need you to participate in making yourself comfortable in the community room before we arrive to treat you.

In terms of how long you want to stay – let us know, when you check in, if you need to be somewhere at a certain time! If you want to be unpinned at a specific time, let us know. We'll make sure you're out on time. In general, if you feel done, open your eyes and give us a meaningful look -- if your eyes are closed, we think you're asleep and we won't wake you up.

### ◆ Community-Mindedness

The soothing atmosphere in our clinic exists because all of our patients create it by relaxing together. We appreciate everyone's presence! This kind of collective stillness is a rare and precious thing in our rushed and busy society. Maintaining this reservoir of calm requires that no one talk very much in the clinic space. If you would like to speak to a practitioner one-on-one at any length, please let us know. If you want to have a substantial conversation, we will probably need to schedule that separately and might need to do it by phone.

If you have questions about acupuncture and how it works -- please visit our website, [www.pleasantoncommunityacupuncture.com](http://www.pleasantoncommunityacupuncture.com). Unfortunately, we can't explain what every point does, or how acupuncture works, while we are treating you -- these are very large topics!. If you have questions, we'll happily give you something to read!

Part of our success is that our patients learn the "routine" and take on a lot of responsibility for the appointments. Re-scheduling and making payment happens at the front desk BEFORE each treatment, so you can relax and enjoy treatment. Please take all personal belongings, (bags, shoes, etc.) with you back into the treatment room. And of course, please turn off your cell phone.

### ◆ Commitment

Acupuncture is a PROCESS. It is very rare for any acupuncturist to be able to resolve a problem with one treatment. In China, a typical treatment protocol for a chronic condition could be acupuncture every other day for three months! Most of our patients don't need that much acupuncture, but virtually every patient requires a course of treatment, rather than a single treatment, in order to get what they want from acupuncture.

One big reason that community acupuncture clinics are able to keep their prices so low is because of the extraordinary amount of marketing their patients do on their behalf -- they don't have to advertise. These patients are such effective marketers because they have first-hand experience of how well acupuncture works. These satisfied patients basically made a commitment to a course of treatment.

On your first visit, your acupuncturist will suggest a course of treatment, which can be anything from "we'd like to see you once a week for six weeks" to "we'd really like to see you every day for the next four days". This suggestion is based on our experience with treating different kinds of conditions. If you don't come in often enough or long enough, acupuncture probably won't work for you. The purpose of our sliding scale is to help you make that commitment. If you have questions about how long it will take to see results, please ask us, or if you think you need to adjust your treatment plan, please let us know. We need you to commit to the process of treatment in order to get good results.

And, last, but not least...enjoy the space. We do, and hope that Body in Balance Community Acupuncture can be an important part of your community. Thank you,

**Body in Balance Community Acupuncture**

# BODY IN BALANCE COMMUNITY ACUPUNCTURE CENTER

## Consent for Treatment by Traditional Chinese Medicine

I, the undersigned hereby authorize Kristine Buckley, L.Ac, MTCM, licensed Acupuncturist in the State of California (Lic # AC 11544) to perform Chinese Medicine treatment methods which may include acupuncture, moxibustion, cupping, Gua Sha, bleeding, herbal therapy, dietary and lifestyle advice.

**I understand that these treatments are all safe, natural methods of healing**

*and I recognize the potential risks and benefits of these procedures as described below*

**POTENTIAL BENEFITS:** Relief of presenting symptoms, improved health and wellbeing, reduced stress and an overall balance of bodily energies which may lead to prevention or elimination of your main complaint(s).

**POTENTIAL RISKS:** Acupuncture - Although uncommon, there is a potential for acupuncture to cause temporary bruising, swelling, bleeding, numbness, tingling, and soreness at the needle site that may last a few days. Unusual risks of acupuncture include dizziness, fainting, nerve damage or possibly the aggravation of symptoms existing prior to treatment. Infection is a slight possibility even though our clinic uses only sterile disposable needles and maintains a clean and safe environment.

**Moxibustion** - Burning of moxa (a Chinese herb – Mugwort) on or near the body has the potential risk of burns, blistering or scarring. **Cupping and Gua Sha** - may cause temporary bruising or redness lasting a few days.

**Herbal Medicine** - Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions. Large doses taken without my practitioner's approval may be toxic and some herbs may be inappropriate during pregnancy.

**PREGNANCY:** Acupuncture can be very beneficial in the treatment of symptoms during pregnancy, assisting in the birthing process and postpartum. I will notify my acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points or herbs that could induce premature labor or miscarriage.

**CANCELATION POLICY:** I recognize that scheduling an appointment involves the reservation of time specifically for me and I agree to give at least 24 hours notice to cancel or reschedule an appointment. A no-show fee of \$20 will be charged for sessions missed without such advance notification.

**PRIVACY:** Since several people are being treated in the same room at once it is vital that we work together to respect your privacy and the privacy of others. Let us know if there are certain topics that need extra discretion or if you prefer to do your intake in a more private setting. If you happen to overhear someone else's private information, please keep it to yourself, you'd want others to do the same for you.

*With this knowledge, I voluntarily consent to the above procedures and policies, realizing that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments regarding the cure or improvement of my conditions. I hereby release Kristine Buckley from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and to discontinue participating in these procedures at any time.*

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Print Name

Signature of Client  
or Person Authorized to Consent

Date



## **BODY IN BALANCE COMMUNITY ACUPUNCTURE**

4133 MOHR AVENUE, STE E  
PLEASANTON, CA 94588  
925.417.8800

### **Financial Policy**

BODY IN BALANCE COMMUNITY ACUPUNCTURE MAKES EVERY ATTEMPT TO MAKE ALTERNATIVE HEALTH CARE, AS ACUPUNCTURE AND CHINESE MEDICINE, AVAILABLE TO AS MANY PEOPLE AS POSSIBLE, AT THE MOST AFFORDABLE RATES.

IN RESPECT FOR OUR INTENTION TO OFFER HIGH QUALITY HEALTH CARE AT AFFORDABLE PRICES, WE ASK FOR 24 HOURS NOTICE IN ADVANCE OF AN APPOINTMENT IF IT IS NECESSARY TO CANCEL OR RESCHEDULE AN APPOINTMENT.

ALL APPOINTMENTS THAT ARE RESCHEDULED OR CANCELLED WITH LESS THAN 24 HOUR ADVANCE NOTICE, AND APPOINTMENTS MISSED WITHOUT NOTICE, WILL BE CHARGED A \$20.00 FEE FOR THAT APPOINTMENT. IF APPOINTMENTS HAVE BEEN PURCHASED IN A PACKAGE, THE MISSED, CANCELLED OR RESCHEDULED APPOINTMENT WILL BE DEDUCTED FROM THE NUMBER OF REMAINING APPOINTMENTS IN THAT PACKAGE.

THANK YOU FOR YOUR UNDERSTANDING,

BODY IN BALANCE COMMUNITY ACUPUNCTURE

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

PRINTED NAME \_\_\_\_\_

BODY IN BALANCE COMMUNITY ACUPUNCTURE CENTER  
4133 MOHR AVENUE, SUITE E  
PLEASANTON, CA 94588  
925.417.8800

### REGISTRATION FORM

CLINIC FILE # \_\_\_\_\_ DATE \_\_\_\_\_

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_  
STREET APT# CITY STATE ZIP CODE

TELEPHONE \_\_\_\_\_  
HOME WORK CELL

EMAIL \_\_\_\_\_

DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ SEX: FEMALE / MALE

WHERE OR FROM WHOM DID YOU LEARN ABOUT BIBCAC? \_\_\_\_\_

PRIMARY CARE PHYSICIAN \_\_\_\_\_

OCCUPATION \_\_\_\_\_ COMPANY NAME \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_  
STREET APT# CITY STATE ZIP CODE

TELEPHONE \_\_\_\_\_  
HOME WORK CELL

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_



## Body in Balance Community Acupuncture Center

Name: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

What is the reason/main complaint for this visit? \_\_\_\_\_

Date of onset? \_\_\_/\_\_\_/\_\_\_

Have you had this problem in the past?  Yes  No

Specify: \_\_\_\_\_

Is this condition:  Improving  Consistent  Getting Worse

What makes it feel better?  Movement  Rest  Heat  Cold Other: \_\_\_\_\_

What makes it feel worse?  Movement  Rest  Heat  Cold Other: \_\_\_\_\_

If there is pain, is it  Mild  Moderate  Severe?  Sharp  Dull  Achy?

On a scale of 1 (no pain) to 10 (worse pain), your pain rates a number \_\_\_\_\_.

### Family Medical History

Do you have a family history of any of the following conditions?

- Diabetes       High Blood Pressure       Heart Disease  
 Cancer       Allergies       Stroke  
 Other: \_\_\_\_\_

### Medical History

Check the appropriate box that pertains to your health history.

Condition		Condition	
Cancer	<input type="checkbox"/> Yes Date: ___/___/___	Allergies	<input type="checkbox"/> Yes Date: ___/___/___
Diabetes	<input type="checkbox"/> Yes Date: ___/___/___	heart Disease	<input type="checkbox"/> Yes Date: ___/___/___
High Blood Pressure	<input type="checkbox"/> Yes Date: ___/___/___	Stroke	<input type="checkbox"/> Yes Date: ___/___/___
Hepatitis	<input type="checkbox"/> Yes Date: ___/___/___	High cholesterol	<input type="checkbox"/> Yes Date: ___/___/___
Asthma	<input type="checkbox"/> Yes Date: ___/___/___	Thyroid Disorder	<input type="checkbox"/> Yes Date: ___/___/___
Immune Disorders	<input type="checkbox"/> Yes Date: ___/___/___	Other:	Date: ___/___/___

**Are you pregnant?**

- Yes  
 No

**Are you trying to conceive?**

- Yes  
 No



## Body in Balance Community Acupuncture Center

Name: \_\_\_\_\_

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Check all that apply:

<p><b>Digestion</b></p> <p><input type="checkbox"/> No Appetite   <input type="checkbox"/> Low Appetite   <input type="checkbox"/> High Appetite</p> <p><input type="checkbox"/> Nausea   <input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Gas   <input type="checkbox"/> Bloating   <input type="checkbox"/> Belching   <input type="checkbox"/> Bad Breath</p> <p><input type="checkbox"/> Indigestion</p> <p><input type="checkbox"/> Abdominal Pain Related to Eating: <input type="checkbox"/> before or <input type="checkbox"/> after</p> <p><input type="checkbox"/> Weight Gain   <input type="checkbox"/> Weight Loss</p> <p><input type="checkbox"/> Heart Burn   <input type="checkbox"/> Ulcers</p> <p>Do you crave <input type="checkbox"/> sweet   <input type="checkbox"/> salty   <input type="checkbox"/> sour <input type="checkbox"/> spicy food   <input type="checkbox"/> sour?</p>	<p><b>Intestines</b></p> <p>How often do you have a bowel movement? per day _____ OR, per week _____</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Loose Stools   <input type="checkbox"/> Undigested Food in Stool</p> <p><input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> Rectal Bleeding: <input type="checkbox"/> Red   <input type="checkbox"/> Brown   <input type="checkbox"/> Black</p> <p>Stool is <input type="checkbox"/> Hard   <input type="checkbox"/> Dry   <input type="checkbox"/> Pebble-like <input type="checkbox"/> Urgent   <input type="checkbox"/> Watery   <input type="checkbox"/> Difficult to Pass</p>
<p><b>Energy Level</b></p> <p><input type="checkbox"/> Too Much   <input type="checkbox"/> Not enough to get thru the day</p> <p><input type="checkbox"/> Right amount to complete daily activities</p>	<p><b>Sleep</b></p> <p><input type="checkbox"/> Restful</p> <p><input type="checkbox"/> Insomnia: <input type="checkbox"/> Problem falling asleep <input type="checkbox"/> Problem staying asleep</p> <p><input type="checkbox"/> Nightmares</p> <p><input type="checkbox"/> Dream-Disturbed Sleep</p> <p>How many hours do you sleep? _____</p>
<p><b>Body Temperature</b></p> <p><input type="checkbox"/> Cold hands   <input type="checkbox"/> Cold feet</p> <p><input type="checkbox"/> Feel cold most of the time</p> <p><input type="checkbox"/> Chills</p> <p><input type="checkbox"/> Feels hot most of the time</p> <p><input type="checkbox"/> Hot Flashes</p> <p><input type="checkbox"/> Feels hot in <input type="checkbox"/> palms   <input type="checkbox"/> feet   <input type="checkbox"/> chest</p> <p><input type="checkbox"/> Alternating between Hot and Cold</p> <p><input type="checkbox"/> Fever, temp. _____ for how long? _____</p> <p><input type="checkbox"/> Excess Thirst</p> <p>Do you prefer <input type="checkbox"/> cold drinks   <input type="checkbox"/> hot drinks <input type="checkbox"/> room temperature?</p>	<p><b>Sweating</b></p> <p><input type="checkbox"/> Night Sweats</p> <p><input type="checkbox"/> Profuse Sweating</p> <p><input type="checkbox"/> Sweat easily with little activity</p> <p><input type="checkbox"/> Sweaty hands   <input type="checkbox"/> Sweaty feet</p>
<p><b>Ears/Eyes/Nose/Throat/Mouth</b></p> <p><input type="checkbox"/> Ringing in the ears: <input type="checkbox"/> Low pitch   <input type="checkbox"/> High Pitch</p> <p><input type="checkbox"/> Ear pain</p> <p><input type="checkbox"/> Hearing Loss</p> <p><input type="checkbox"/> Dry Eyes</p> <p><input type="checkbox"/> Blurred Vision</p> <p><input type="checkbox"/> Eye Pain</p> <p><input type="checkbox"/> Floaters</p> <p><input type="checkbox"/> Runny Nose   <input type="checkbox"/> Sneezing</p> <p><input type="checkbox"/> Sinus Congestion   <input type="checkbox"/> Frequent Colds/ URIs</p> <p><input type="checkbox"/> Sore Throat</p> <p><input type="checkbox"/> Nose Bleeding</p> <p><input type="checkbox"/> Bleeding Gums   <input type="checkbox"/> Grinding Teeth</p>	<p><b>Chest/Respiratory</b></p> <p><input type="checkbox"/> Shortness of Breath</p> <p><input type="checkbox"/> Wheezing</p> <p><input type="checkbox"/> Dry Cough at <input type="checkbox"/> Night   <input type="checkbox"/> Day   <input type="checkbox"/> All the time</p> <p><input type="checkbox"/> Productive Cough with Phlegm: Color: _____ Consistency: <input type="checkbox"/> thin   <input type="checkbox"/> thick</p> <p><input type="checkbox"/> Chest Pain</p> <p><input type="checkbox"/> Chest Distention</p> <p><input type="checkbox"/> Rib Pain</p> <p><input type="checkbox"/> Palpitations</p>



## Body in Balance Community Acupuncture Center

Name: \_\_\_\_\_

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### Neurological

Headaches; How often? \_\_\_\_\_

Where? \_\_\_\_\_

Known causes? \_\_\_\_\_

Dizziness  Vertigo

Memory Loss

Seizures

If  Tremors  Numbness  Tingling,  
where? \_\_\_\_\_

### Urinary System

Frequent Urination:  Day  Nite  All day

Difficult Urination

Dribbling

Urgent

Incontinence

Burning Urination

Blood in urine

Frequent Urinary Tract Infections

### Emotions

Anxiety

Easily Angered

Irritable

Nervous

Moody

Depressed  Manic

Cry easily

Fearful

Grieving

### Personal Habits

Do you:

Smoke: how much? \_\_\_\_\_

Drink Alcohol: how many glasses/wk \_\_\_\_\_

Drink Coffee: cups/day \_\_\_\_\_

Drink Tea: cups/day \_\_\_\_\_

Exercise: how often \_\_\_\_\_

What do you do? \_\_\_\_\_

### Medication/Herbs/Supplements

List all:

### Female

Date of last period: \_\_\_\_\_

No. of days period lasts: \_\_\_\_\_

No. of days btw periods: \_\_\_\_\_

Are your periods regular?  yes  no

Color:  Red  Bright Red  Dark Red

Pale  Brown

Consistency:  Thin  Thick

Clotting

Cramps:  Before, how many days? \_\_\_\_\_

During, how many days? \_\_\_\_\_

Better with heat

Better with rest

### Health

Breast Tenderness

Mood Changes

Food Cravings

Low Back Pain

Spotting Btw Periods

Hot Flashes

Vaginal Dryness

Libido:  Too low  Too high

## Consent for Purposes of Treatment, Payment and Health Care Operation

I consent to the use or disclosure of my identifiable health information by Body in Balance Community Acupuncture Center (known as BIBCAC) for the purposes of diagnosis or providing treatment to or to conduct health care operations. I understand that diagnosis or treatment of me at BIBCAC may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment or health care operations of the practice. BIBCAC is not required to agree to the restrictions I may request. However, if BIBCAC agrees to a restriction that I request, the restriction is binding upon BIBCAC.

I have the right to revoke this consent, in writing, at any time except to the extent that BIBCAC has taken action in reliance on this consent.

My identifiable health information means health information, including my demographic information, collected from me and created or received by my practitioner or another health care provider. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review BIBCAC's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations of BIBCAC. This Notice of Privacy Practices also describes my rights and the duties of my practitioners with respect to my identifiable health information.

BIBCAC reserves the right to change information contained in the Notice of Privacy Practices any any time. I may obtain a revised Notice of Privacy Practices by accessing the most current notice during any office visit.

\_\_\_\_\_ date: \_\_\_\_\_  
Signature of Patient or Authorized Representative

\_\_\_\_\_