Welcome to Common Good Acupuncture

We are delighted that you have decided to try acupuncture with us!

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 our business

CGA is modeled after Working Class Acupuncture in Portland, Oregon.

Our goal as a new clinic is to provide as much affordable acupuncture as possible and to create/maintain a living-wage job for our acupuncturist(s). We depend entirely on fees for service. Our payment structure is sliding scale so you can get enough treatment for it to work! If you enjoy your experience, please tell your friends and neighbors, take a few business cards, or consider leaving us a review online. Referrals are the best way people find out about us!

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.

Cell phones, watches, and anything that makes noise must be turned off before entering the clinic.

With community acupuncture, we treat everybody in a shared space, in "zero gravity" recliners. You do not need to disrobe. Once you are in a chair, roll up your pants & sleeves, take off your shoes & socks if you are comfortable doing so.

Talking is kept at a minimum. Most conversations happen at the whisper level because there is usually at least one person resting at any given time. Privacy is attempted but cannot be guaranteed. You are welcome to write a note if you don't want anyone near by to hear what you're getting treated for.

After your acupuncturist puts the needles in, your job is to relax and let them work. Minimum treatment time recommended to sit with the pins is 20 minutes. In order to give the most amount of care, we will remove your needles after a maximum of 60 minutes. When you feel ready to go, open your eyes and give us a nod when we are in between treatments. Do not get up out of your chair with needles in! We'll come over and take your needles out. Sometimes needles fall out on their own and that is normal- We do not need to replace them and will collect fallen needles at the end of your treatment. If it is an emergency that can't wait, please use your voice to ask for help.
Please do not linger in your chair afterward to check your phone- Other patients may be waiting to sit right away.

Ambient music and white noise machines play in the treatment room. People do snore sometimes, so if that bothers you, 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. Please know that we regularly launder all linens to ensure cleanliness and good hygiene.

Punctuality is extremely important! Even though your appointment lasts for 60 minutes, you are booking 20 minutes with an acupuncturist for new appointments and 10 minutes for return appointments. If you are late for your appointment, we will make out best effort, but must prioritize other patients' standing appointments and cannot guarantee that we will be able to see you. You will be charged for the appointment if you are overly late (more than 15 min) or miss your appointment.

Please note that we have a 24-hour cancellation policy. If you must cancel your appointment with less than 24 hours' notice you will be charged $47 for new patient appointments and $37 for return patient appointments. If you have treatment credits, 1 will be deducted from your account instead of being charged. We must enforce this policy regardless of unexpected travel delays and other life events.

Patient Information	Contact Information
Today's date _____/_____/_____ Name_____ Birth date_____ Age_____ Preferred pronouns (optional)_____ Occupation _____ Company Name_____ How did you hear about us?_____ _____	Address _____ City _____State _____Zip_____ Cell phone_____ Alternate 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_____Don't know_____

SIGNATURE

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

Signature _____**Date** _____/_____/_____

Common Good Acupuncture PLLC -
ACUPUNCTURE INFORMED CONSENT TO TREAT

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 the acupuncturist(s) who now or in the future treat me at Common Good Acupuncture. This treatment may include, but is not limited to: acupuncture, ear seeds, gua sha, cupping, moxa, bleeding, tui na (Chinese medical massage), and herbs. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the 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: Spontaneous miscarriage, seizures, nerve damage, and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile, single-use disposable needles and maintains 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 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 chair. 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 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 to be able to anticipate or explain all possible risks and complications of treatment and I wish to rely on the clinical staff to exercise judgment during the course of treatment, which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand 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.

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that may be or have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue.

I understand that any future hired clinical and administrative staff of Common Good Acupuncture may review my patient records and/or lab reports, but all my records will be kept confidential and will not be released without my written consent.

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 if I have questions about my treatment or about the risks and benefits of acupuncture. I will notify acupuncturist if I am or become pregnant.

By voluntarily signing, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____

Patient Name Patient Signature (or Representative) Date

_____

Acupuncturist Name Acupuncturist Signature Date

COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.
I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.
To proceed with receiving care, I confirm and understand the following
• I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to- person contact, in which COVID-19 can be transmitted.• I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to

defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time.
• I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office.
• I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:

*Fever *Shortness of Breath *Dry Cough *Runny Nose *Sore Throat *Loss of Taste or Smell *Sore Throat *Loss of Taste or Smell

• I understand travel increases my risk of contracting and transmitting the COVID-19 virus.
• I am informed that Common Good Acupuncture has implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment, especially if I choose not to wear a mask. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care.
• I am able to request a copy of this consent form at any time or can access it online at commongoodacu.com

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY CHECKING THE BOXES BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Common Good Acupuncture PLLC- 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 $37 as a returning patient or $47 as a new patient. The last thing we want is for you to pay and 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 do so through the online scheduler. We do

not have a receptionist and do not answer calls during clinic hours. Please do NOT email us about cancellations.

3. I hereby expressly waive and release any and all claims, now known or hereafter known, against Common Good Acupuncture and its affiliates on account of anything arising outside of the ordinary, as explained, related to my participating in receiving treatment.

By signing this form, I understand I am a cooperative participant in my treatment at Common Good Acupuncture. I have read this information (or had it read to me), and I have had an opportunity to ask questions. By checking each box below and signing below I voluntarily give consent to receive acupuncture as treatment for my present condition and for any future conditions.

- **I have read and I understand the Consent to Treat Form.** ☐
- **I have read and I understand the COVID-19 Informed Consent to Treat Form.** ☐
- **I have read and I understand the Patient Responsibilities information.** ☐
- **New York law requires that we encourage you to see an MD (medical doctor) for any health problems you are experiencing. Please check the box to acknowledge that you have read and understood this statement.** ☐
- **I have read and I understand the cancellation policy. I agree to pay the full price for any appointments missed without 24-hour notice.** ☐
- **I agree that Common Good Acupuncture is in no way responsible for the safekeeping of my personal belongings at 98b Suydam Street Brooklyn NY 11221 while I am in treatment.** ☐

_____

Patient Name | Patient Signature (or Representative) | Date

_____

Acupuncturist Name | Acupuncturist Signature | Date

Thank you for your patience and for reading this form. If you have any questions, please reach out to us via phone or email commongoodacu@proton.me