Neighborhood
Acupuncture & Healing Arts, LLC
12582 South Fort Street
Draper, UT, 84020
P:801-662-8610

This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. Please fill it out as completely as possible. Thank you.

General Information Today's Date _____/_____/_____

Full Name: _____

Date of Birth_____/_____/_____ Gender: □M □F

Mailing Address_____

City_____ State_____ Zip_____

Phone_____E-mail_____

Occupation_____

Would you prefer to receive notifications and reminders via □ Email □ Text *Mobile provider _____

Are you interested in receiving our email newsletters? □ Yes □ No

Person responsible for your account_____ Relationship:_____

Emergency Contact: _____ Relationship:_____

Emergency Contact Phone Number: _____

Whom should we thank for referring you? _____

Have you had acupuncture before? □ Yes □ No If so, where?

Are you interested in additional health services besides acupuncture? □ Yes □ No

Please check all services you are interested in:

□ Yoga Lessons □ Relaxation techniques □ Chinese Herbs □ Acupuncture □ Nutrition □ Body Work

What is the primary condition you would like to have treated? _____

When did the condition begin? _____

On a scale of 0 to 10 how sever are your symptoms: (0 is no symptoms and 10 very sever)? Worst: _____Average: _____Best: _____

What other forms of treatment have you sought? _____

What is the second condition you would like to have treated? _____

When did the condition begin? _____

On a scale of 0 to 10 how sever are your symptoms: (0 is no symptoms and 10 very sever)? Worst: _____Average: _____Best: _____

What other forms of treatment have you sought? _____

What is the third condition you would like to have treated? _____

When did the condition begin? _____

On a scale of 0 to 10 how sever are your symptoms: (0 is no symptoms and 10 very sever)? Worst: _____Average: _____Best: _____

What other forms of treatment have you sought? _____

Please List any other healthcare practitioners you are seeing including Primary Health Care, surgeons, Physical Therapists, Chiropractors, Massage Therapists, Nutritionists etc.

Name: _____ Practice Name _____ Phone Number _____

Name: _____ Practice Name _____ Phone Number _____

Name: _____ Practice Name _____ Phone Number _____

II. Patient Medical History

Significant childhood health issues: _____

Current Immunizations:_____

Please list ALL Hospital Stays, Surgeries, Significant Trauma (auto accidents, falls, broken bones, etc.) with approximate dates:

_____

_____

Recent tests: (please indicate test results and date below)

❑Physical ❑Cholesterol ❑Prostate ❑Blood ❑HIV/STD ❑Pap smear ❑Mammography

❑Urinalisis ❑Endoscopy ❑ Colonoscopy ❑EKG ❑MRI ❑Other:_____

Significant Results:_____

Check any of the following you have been diagnosed for:

❑Any heart illnesses	❑ Any lung illnesses	❑Any liver illnesses	❑Any Endocrine Disorder	❑High fever
❑CVA (stroke)	❑Asthma	❑Herpes	❑Diabetes	❑Measles
❑Arteriosclerosis	❑Allergies	❑Gout	❑Thyroid Disorder	❑Mumps
❑Vein condition	❑Pneumonia	❑Hepatitis	❑PCOS	❑Meningitis
❑Bleeding tendency	❑Emphysema	❑Jaundice	❑Nervous disorder	❑Scarlet Fever
❑Pacemaker	❑Tuberculosis	❑Fibromyalgia	❑Paralysis	❑Chicken pox
❑High blood pressure	❑Mononucleosis	❑Migraines	❑Epilepsy	❑HIV
❑Rheumatic Fever	❑Lyme's Disease	❑Glaucoma	❑Multiple Sclerosis	❑Gonorrhea
❑Any kidney illnesses	❑Any Prolapsed organs	❑Cancer	❑Seizures	❑Polio

Other:_____

Current Medications and Supplements:

Please list any prescriptions, over the counter medications, nutritional supplements, or herbs you currently take at least once per week.

Name, Dosage, year prescribed	Condition / Reason	Experienced Effects & Side Effects
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Alcohol & Drug use

❑Coffee # of cups per day _____ _____

❑Soda pop # per day_____

❑ Tobacco # of cigarettes per day _____

❑Former Tobacco use, year quit?_____

❑Alcohol # of drinks per week _____

❑Former Alcohol use, year quite? _____

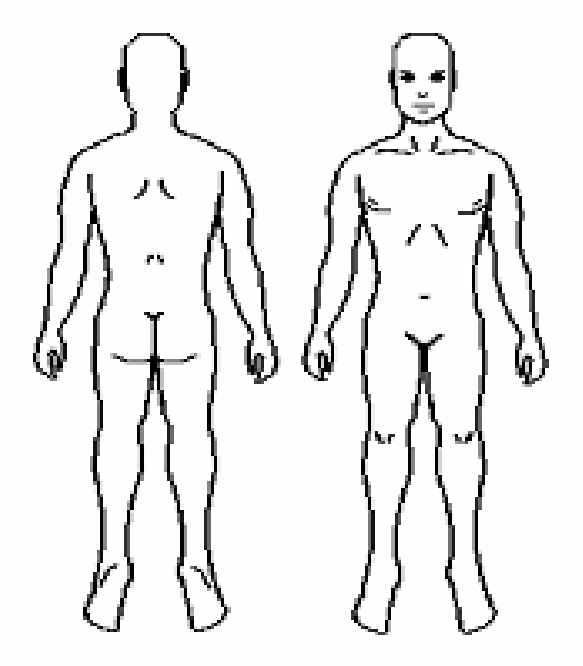
❑Recreational Drug use _____

❑ Former recreational drug use year quite? _____

III. Patient's Pain Profile

Please closely circle any area's that you have pain or discomfort at least 1 time per month

Left Right Right Left



Please *answer the following questions for each area that you have marked if different from page 1*

When did the pain originally begin? _____

_____

What where the circumstances?_____

_____

What is the location of the pain or discomfort?_____

_____

How often do you experience the pain and how long does it last?_____

_____

What is the character of the discomfort?_____

_____

What treatments or what conditions help the pain?_____

_____

What situations aggravate the pain?_____

_____

When the pain is the best? _____

When it is the worst?_____

Acupuncturist Notes:

Visit #	Visit #	Visit #	Visit #	Visit #	Visit #	Visit # 1	**Overall Musculoskeletal System:** How would you qualify your overall pain / discomfort levels? Have you developed any recent changes in your muscles, bones, or joints? How frequently do you exercise? What type of exercise do you do?
							Muscles, Bones, Joints
							❑Acute Pain (short-term pain)
							❑Chronic Pain (long-term pain)
							❑General Aches
							❑Sensation of heaviness in the body
							❑Muscle Weakness
							❑Muscle Cramps
							❑Muscle Twitching
							❑Muscle Spasms
							❑Muscle Atrophy
							❑Limited Range of Motion
							❑Arthritis
							❑Joint Pain
							❑Swollen Joints
							❑Joint Instability
							❑Bone Pain
							❑Easily broken bones
							❑Sensation of heat in the bones
							The Pain Is:
							❑ Sharp
							❑Dull
							❑Aching
							❑Numb
							❑Superficial Pain
							❑Deep Pain
							❑Burning
							❑Tingling
							❑Shooting

Visit #	Visit #	Visit #	Visit #	Visit #	Visit #	Visit #	**Overall Temperature:** Do you tend to run warm or cool? What is your preferred temperature and favorite season? Have your body temperature or sweating patterns changed recently?
							❑Cold hands or fingers
							❑Cold feet or toes
							❑Cold body temperature
							❑Lack of perspiration
							❑Prefer warm drinks
							❑Feel cold most of the time
							❑Alternating fever and chills
							❑Heat in the hands, feet, or chest
							❑Sweaty hands or feet
							❑Hot body temperature
							❑Perspire easily
							❑ Prefer iced drinks
							❑Afternoon flushes
							❑Night sweats
							❑Hot flashes any time of the day

Visit #	Visit #	Visit #	Visit #	Visit #	Visit #	Visit # 1	**Overall energy and Immune System:** Have you been diagnosed with an immune system disorder? How would you qualify your overall energy level? How would you qualify your overall health? How frequently do you get a common cold or flu?
							❑Drowsiness during the day
							❑General weakness
							❑Low energy
							❑Feel worse after exercise
							❑Frequently sick
							❑Never get sick
							❑Chronic Mental Cloudiness
							❑Slow Wound Healing
							❑Tender/Achy All Over
							❑Less Ability to Adapt to Change

Visit #	Visit #	Visit #	Visit #	Visit #	Visit #	Visit # 1	**Emotions:** Have you been diagnosed with an emotional disorder? How would you qualify your overall emotional state? How do you respond to stress? What do you do to relieve stress? Have your emotions changed recently?
							❑Panic attacks
							❑Anxiety or Nervousness
							❑Restlessness
							❑Poor Memory
							❑Difficult concentration
							❑Mental confusion
							❑Over-thinking or Worry
							❑Pensive
							❑Unresolved Grief
							❑Low Self Esteem or Self Worth
							❑Easily Stressed
							❑Depression or Sadness
							❑Easily Frustrated
							❑Anger easily
							❑Easily startled
							❑Frightened Easily
							❑Fear
							❑Trauma or Abuse Survivor
							❑Suicidal tendency
							❑Receiving Counseling

Visit #	Visit #	Visit #	Visit #	Visit #	Visit #	Visit # 1	**Overall Gastrointestinal Health:** Have you been diagnosed with any digestive disorders? Please describe your appetite: How much food does it take to feel satisfied? Do you have any dietary restrictions? Average breakfast: Average lunch: Average dinner: Average snacks: How frequently do you have a bowel movement? Have you had any recent changes in your digestion?
							Appetite
							❑Low appetite
							❑Fatigue after eating
							❑Large appetite
							❑Abrupt weight gain
							❑Abrupt weight loss
							Mouth
							❑Bad Breath
							❑Mouth (canker) sores
							❑Bleeding, swollen or painful gums
							❑Frequent cavities
							❑Teeth removed
							❑Teeth grinding / TMJ
							❑Lip Sores / Cold sores
							❑Bitter taste in the mouth
							❑Dry mouth
							Digestion
							❑Hiccoughs
							❑Belching
							❑Nausea or Vomiting
							❑Vomiting Blood
							❑Acid Regurgitation/Reflux
							❑Bloating or Indigestion
							❑Gurgling noise in the stomach
							❑Severe stomach or Intestinal pain
							❑Gall stones (past or current)
							❑Ulcers
							❑Hernia
							❑Gas/Flatulence
							Bowel movements
							❑Dark Colored Stool
							❑Light Colored Stool
							❑Blood or Mucus in Stools
							❑Constipation
							❑Diarrhea or Loose Stool
							❑Alternating diarrhea /constipation
							❑Incomplete bowel movement
							❑Hard stool
							❑Painful bowel movements
							❑Hemorrhoids or Fissures
							❑Rectal Pain/Itching/Burning
							❑Undigested food in stool

Visit #	Visit #	Visit #	Visit #	Visit #	Visit #	Visit # 1	**Sleep:** Have you been diagnosed with a sleeping disorder? What time do you go to bed? What time do you wake up? How long does it take to fall asleep? How often do you wake up during the night? On average how many hours of sleep do you get per night? How would you qualify your overall sleep? Have your sleeping patterns changed recently?
							❑Trouble falling asleep
							❑Trouble staying asleep
							❑Trouble falling back asleep
							❑Waking during the night to urinate
							❑Frequent dreams
							❑Dream disturbed sleep
							❑Tossing and turning through night
							❑Snoring

Visit #	Visit #	Visit #	Visit #	Visit #	Visit #	Visit #	**Overall Cardiovascular function:** Have you been diagnosed with any heart or circulatory conditions? How would you rate your overall heart health?
							❑Chest Pain
							❑Tight sensation in the chest
							❑Hypertension /High Blood Pressure
							❑Hypotension / Low Blood Pressure
							❑Rapid Heart Rate
							❑Irregular Heart Rate
							❑Slow Heart Rate
							❑Palpitations
							❑Fainting
							❑Blood Clots
							❑Edema (Swelling)
							❑Pacemaker
							❑Varicose veins
							❑Phlebitis
							❑Poor circulation

Visit #	Visit #	Visit #	Visit #	Visit #	Visit #	Visit #	**Overall Respiratory function:** Have you been diagnosed with any lung conditions? How would you rate the overall health of your lungs?
							❑Difficulty Breathing
							❑Shortness of breath on exertion
							❑Shortness of breath at rest
							❑Acute Cough
							❑Chronic cough
							❑ Dry cough
							❑Coughing blood
							❑Cough up mucous
							❑Phlegm/Congestion
							❑Asthma
							❑Allergies (_____)
							❑Tight Chest
							❑Chest congestion
							❑Wheezing
							❑Rattling Sound with Breath
							❑Pleurisy
							❑Pneumonia
							❑Can't Sleep Lying Down

Visit #	Visit #	Visit #	Visit #	Visit #	Visit #	Visit # 1	**Overall Kidney Health:** Have you been diagnosed with any kidney or bladder disorders? What all do you drink through the day: How frequently do you urinate throughout the day? Throughout the night? Have you experienced any recent changes to your thirst or urination?
							❑Clear urine
							❑Pale Yellow urine
							❑Dark yellow urine
							❑Reddish urine
							❑Cloudy urine
							❑Scanty amount of urination
							❑Profuse amount of urination
							❑Frequent urination
							❑Urgent urination
							❑Incomplete urination
							❑Dribbling
							❑Trouble starting stream
							❑Lack of bladder control
							❑Incontinence
							❑Bed Wetting
							❑Urinary tract infections
							❑Strong odor
							❑Difficult urination
							❑Burning sensation
							❑Painful urination
							❑Kidney infections
							❑Kidney stones

Visit #	Visit #	Visit #	Visit #	Visit #	Visit #	Visit # 1	**Skin, Hair and Nails:** Have you been diagnosed with any skin, hair, or nail disorders? How would you describe the overall condition of your skin and hair? Have you experienced any changes in your skin or hair recently?
							❑Easily Bruised
							❑Dry Skin
							❑ Chapped Lips
							❑Oily Skin
							❑Rashes
							❑Hives
							❑Acne
							❑Itching
							❑Ulcerations
							❑Psoriasis
							❑Eczema
							❑Lumps
							❑Sores
							❑Moles that changed
							❑Dry Hair
							❑ Oily Hair
							❑Dandruff
							❑Hair Loss
							❑Hair Breaking
							❑Premature Graying
							❑Thin Nails
							❑Easily Broken Nails
							❑ Slow Growing Nails
							❑Fungal Infection
							❑Misshaped Nails

Visit #	Visit #	Visit #	Visit #	Visit #	Visit #	Visit # 1	**Eyes, Ears, Nose, Throat** Have you been diagnosed with any conditions of your eyes, ears, nose or throat? Have you experience any changes of sight, hearing or smell recently?
							EYES
							❑Itchy
							❑Bloodshot
							❑Hot
							❑Dry
							❑Watery
							❑Gritty
							❑See floating spots in eyes
							❑Blurry vision
							❑Decreased night vision
							❑Near-sighted
							❑Far-sighted
							❑Glaucoma
							❑Cataracts
							EARS
							❑High-pitched ringing in the ears
							❑Low-pitched ringing in the ears
							❑hearing loss
							❑Earaches
							❑Ear pain
							❑Clogged / popping ears
							NOSE
							❑Sneezing
							❑Nasal Discharge Color: _____
							❑Nose Bleeds
							❑Sinus Congestion
							❑Dry throat
							❑Dry Nose
							❑Post Nasal Drip
							THROAT
							❑Frequent sore throat
							❑Lump in the throat
							❑Throat drainage
							❑Swollen Glands
							❑Enlarged Thyroid
							❑Throat tickle

Visit #	Visit #	Visit #	Visit #	Visit #	Visit #	Visit # 1	**Nervous System:** Have you been diagnosed with a nervous system disorder?
							❑Dizziness or Vertigo
							❑Loss of balance
							❑ Tremors
							❑Convulsions
							❑Numbness or Neuropathy
							❑Nerve Pain
							❑Seizures or Epilepsy
							❑Paralysis
							❑Stroke
							❑Bells Palsy
							❑Trigeminal Neuralgia
							❑Multiple Sclerosis

Women's Health:

Age of first period (Menarche) _____ Age of Menopause _____ Date of previous period _____

Pregnancies _____ # Miscarriages _____ # Abortions _____ # Live births _____ #Premature births _____

Are you currently pregnant? ❑Y ❑N Could you possibly be pregnant? ❑Y ❑N Are you trying to get pregnant? ❑Y ❑N

Are you currently sexually active? ❑Y ❑N How often? _____ Number of partners in the last year: _____

Current method of Birth control_____ Past methods _____ Reason _____

Date of PAP_____/_____/_____ Date of Mammogram _____/_____/_____ Date of Bone density scan _____/_____/_____

Are you using Hormone Replacement Therapy ❑Y❑N

Have you ever been diagnosed with a reproductive disorder? _____

❑ Fibroids ❑ Fibrocystic breasts ❑ Endometriosis ❑ Ovarian cysts ❑ PID ❑Polycystic Ovary Syndrome

❑ STD _____ ❑Reproductive cancer_____ ❑Other _____

Infertility Information # of IVF procedures_____ # of IUI procedures_____

Has a physician diagnosed a difficulty with fertility due to: ❑ Female Factor ❑ Male Factor ❑ Unexplained

PMS: Please check any of the symptoms you experience the week before your period

❑Headaches	❑Irritability	❑Food cravings	❑ Breast discomfort	❑Lower abdomen pain
❑Migraines	❑Depression	❑Nausea	❑Breast swelling	❑ Low back pain
❑ Break out	❑Anxiety	❑Vomiting	❑Bloating	
❑Mood swings	❑Other emotions	❑Change of bowel movement	❑Water retention	

Menstrual Cycle

Number of days between periods (From the first day of flow to the following first day of flow) _____Number of days of flow_____

(check all that apply): ❑Regular Cycle ❑Irregular menstruation ❑Spotting between periods ❑ Amenorrhea ❑Hysterectomy

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Number of pads or tampons							
Color of flow*:							
Consistancy**:							
Pain: how sever 1-10							
Pain: location							
Nausea or Vomiting							
Other							

*Color: bright red, pale red, brown, rust, dark, purple **Consistency: is the flow thick, mucusy, stringy, watery, Clots (size and shape)

Breast Health
❑Regular Self Breast Exams
❑Breast Lumps
❑Mastectomy
❑Lumpectomy
❑ Nipple pain or discharge
❑ Unmovable breast lumps

Vaginal Health
❑ Yeast infections
❑ Vaginal itching
❑ Vaginal irritation
❑ Profuse discharge
❑ Vaginal dryness
❑Vaginal Odor

Ovulation
❑Cervical Mucus
❑Excessive Mucus
❑Dry Mucus
❑ Ovulatory Pain
❑Bloating
❑ Mood Changes

Sexual Health
❑Decreased Libido
❑Increased Libido
❑Pain during intercourse
❑Lack of interest
❑Inability to orgasm

Patient Signature:_____ Acupuncturist Signature:_____

Acupuncture Treatment

Acupuncture

In order to reduce the cost of our treatments we have implemented a high volume and low cost model in a semi-private treatment room. In order for this model to work we depend on our clients to arrive to their appointments on time.

If you are ever uncomfortable during your treatment either from position or from the acupuncture treatment please tell your practitioner immediately so they may rectify the situation to make you more comfortable. Acupuncture treatments are not always comfortable and often a weird or uncomfortable sensation may occur at the sight of the needle. This sensation is considered beneficial and a healing reaction. However if you ever have a sensation you would qualify as painful especially of the sharp or electrical nature please tell your acupuncturist immediately. You have the ability at any time during your treatment to ask for a needle to be removed or adjusted to make you more comfortable.

Acupuncture treatments are allotted 1 hour from the beginning of your scheduled appointment. You have the ability to end your session sooner for any reason. Each room has a monitor so that if you need assistance during your treatment or when you are ready to end your treatment the acupuncturist will be able to hear you. If the acupuncturist is assisting another client it may take up to 10 minutes for them to come and assist you but they will be with you as soon as possible. Please be patient as we are doing our best to accommodate multiple people at the same time. If you have called for the acupuncturist and do not receive and answer within 5 minutes please call again and allow another few minutes as the acupuncturist may have been out of the office and did not hear you the first time.

Outside of the most extreme of situations it is never acceptable for a client to remove their own acupuncture needles. As a health care clinic the acupuncturist or assistant need to account for every single needle and make sure that it is properly disposed in the safest of manors. When clients remove their own needles we cannot guarantee that all needles have been disposed of safely and this poses a great health concern for all clients entering our space.

Before treatment:

- Eat a few hours before treatment
- Use the restroom before procedure
- If you are thirsty, get a drink
- Wear loose-fitting clothing to allow Acupuncturists access to your arms below the elbow and legs from the knee down.

Starting the treatment:

- Select a chair, roll sleeves to elbows and pants to knees, remove socks and shoes
- If you are in an uncomfortable position, support can be provided. Tell your Acupuncturist so they can provide a bolster.
- You will cool down quickly, so grab a blanket if needed.
- Choose whichever position is most comfortable in the chair. It will not affect the treatment to lie down or sit up. Get comfortable before the procedure begins as motion will be limited after insertion of the acupuncture needles.
- Once the needles are inserted, try not to move as it can aggravate the needles. If movement is necessary, move from the shoulder/elbow; avoid wiggling fingers and twisting the wrist.

During the treatment there are 3 potential sensations:

- Insertion of the needle: you might feel nothing or a slight pinch.
- Needle activates a healing reaction: you might feel nothing or there might be a weird and uncomfortable feeling.
    - descriptive words often associated with the sensation of acupuncture: weird, hot, cold, light, heavy, itching, tingling, dull, aching, throbbing
    - If you feel Sharp or electrical pain that is very strong and intense- tell the Acupuncturist immediately so that the needle can be removed. Needle insertion that causes sharp pain can potentially cause nerve damage if prolonged.
- Body goes into rest and digest mode: during this stage you will feel deeply relaxed; this state lasts from 20 -60 minutes; once the feeling has subsided, you will be widely awake.
- Once you are alert, or if you are uncomfortable for any reason, ring the bell, if no one comes within 5 minutes ring the bell again but louder. Keep your eyes open and make eye contact so that the acupuncturist knows you rang the bell and would like assistance.
- After the treatment you will need to avoid strenuous activity for 72 hours. Activity that is normal for you is okay.

What to expect from an acupuncture treatment: (risks and possible side effects)

- Herbs - take with food if they upset the stomach
- Bruising – this only happens with 1 out of 100 needles. If bruising happens frequently, the needle size will be reduced.
- Aching or tenderness at insertion site is common and usually will disperse between 2-24 hours. Appling heat and massaging the point will usually help resolve any discomfort. Rarely the tenderness will last longer than a day, if you have any pain that lasts longer than a day please contact the acupuncturist.
- *Clean needle technique is used, which means that all needles are used once and then disposed of, the insertion site is cleaned with rubbing alcohol and the acupuncturists hands are sanitized before and after each patient.*

- **Arrival Time:**
- I understand that I must plan to arrive 10 minutes early for my appointment to allow time for checking in, using the restroom, filling out medical history forms and getting settled. _____
- I understand that if I am running late, my appointment may still have to end on time, so as not to delay the next guest. _____
- I understand that appointments cut short due to late arrival are payable in full. _____
- I understand that the teachers and therapists are scheduled to arrive 15 minutes prior to their classes and appointments, and that if I am more than 15 minutes early the clinic may not be open yet for treatments. _____
- I understand that if I arrive early and the clinic is open, naahac cannot guarantee that I will be seen before my scheduled appointment time. _____
- **Cancellation Policy:**
- I understand that cancellations can be made within 3 hours of my appointment without charge. _____
- I understand that I can cancel either through the online scheduling system or by phone. _____
- I understand that cancelling with less than 3 hours notice will incur a fee of $15 and may be cancelled by calling or texting 801-662-8610 _____
- I understand that exceptions to the cancellation policy will be made for sudden injury and contagious illness on a case by case basis and will be determined by Neighborhood Acupuncture and Healing Arts, LLC. _____
- **No-Show Policy:**
- I understand that if I either forget or consciously choose to forgo my appointment for whatever reason I will be considered a "no-show". _____
- I understand that if I no show an appointment, I will be required pay in full and it will be a non-refundable fee. I understand this will still apply if I am on an unlimited package. _____
- I understand that any fees for late cancellations or failure to cancel an appointment will be charged to my account and will need to be paid before my next service or class. _____
- I understand that future service will be denied until all fees are paid in full. _____
- I understand that the only exception to this policy is emergency room visits that occur during the same time as my appointment and proof of the visit must be rendered to reverse this fee. _____
- **Return/Refund Policy:**
- I understand that refunds will be given for any prepaid unused treatments with a written request. _____
- I understand that if a refund on a package is requested or if a package expires the full price for each service rendered will be deducted and any remaining balance will be refunded either to my account or in the manor that I paid for my package. _____
- I understand that if a refund is requested for an auto pay contract before the contract has expired the full priced amount for any service rendered up to the amount of the package will be deducted and an additional $50 fee will be charged for breaking the contract. Any remaining balance will be refunded. _____
- I understand that with breaking an auto pay contract, if I have used the full amount of the contract price, I will be additionally responsible for the $50 fee. _____
- I understand that if a refund is given for a package or contract, I may no longer be eligible for future purchases of discounted services. All future services will be paid at the time of service for the full price of the service. _____
- I understand that refunds given to a credit or debit card may take up to 30 days to be returned on the card. _____
- **Purchase Policy**
- I understand that cash, personal checks and Visa, Master Card, American Express, and Discover are accepted for services and any product purchases at Neighborhood Acupuncture & Healing Arts. _____
- I understand that payment is due at the time services and/or products are received. _____
- I understand that a $25.00 fee will be applied to all dishonored payments (returned checks or credit card payments). _____
- I understand that all prices are subject to change. _____

- I understand that gratuity in not included in the service price nor am I required to tip my therapist (but the
- generosity is greatly appreciated). _____
- **Packages and Contracts**
- I understand that 5 packs offer a 5% discount and this promotional value will expire 12 months from the time of purchase. _____
- I understand that 10 packs offer a 10% discount and this promotional value will expire 12 months from the time of purchase. _____
- I understand that 20 Packs offer a 20% discount and this promotional value will expire 12 months from the time of purchase. _____
- I understand that numbered packages may be shared between friends and family members. _____
- I understand that unlimited packages are non-transferable. _____
- I understand that Auto-pay contracts may be paused once per year for up to 6 months with a 30 day written notification. _____
- I understand that to break a contract before the allotted payments will incur a $50 fee. _____
- **All Treatments and Classes**
- We work very hard to make sure that each client receives personalized attention and is made as comfortable as possible during their treatments. This requires an open communication between the client and the practitioner. _____
- I understand that if I ever have something to communicate with my practitioner that I would prefer to talk about in private, I will need to ask to speak to my practitioner before my treatment in the consultation room. _____
- I understand that it is my responsibility to inform my practitioner of any changes in my health or any new treatments I am receiving before my treatment or class. _____
- I understand that Neighborhood Acupuncture and Healing Arts reserves the right to refuse services to anyone at any time or end a session with a client who is not respectful, or makes any unwanted comments or advances to the practitioners, other clients, or any other person on the premises. _____
- I understand that for my safety, Neighborhood Acupuncture & Healing Arts will not allow any person to receive treatments or to attend classes if they are intoxicated. _____
- **Acupuncture**
- I understand that if I am ever uncomfortable during a treatment, either from position or from the acupuncture treatment, it is my responsibility to tell the practitioner immediately so they may rectify the situation. _____
- I understand that acupuncture treatments are not always comfortable and often a weird or uncomfortable sensation may occur at the sight of the needle. This sensation is considered beneficial and a healing reaction. _____
- I understand that if I ever have a sensation that I would qualify as painful, especially of the sharp or electrical nature, it is my responsibility to tell the acupuncturist immediately. _____
- I understand that I have the ability at any time during my treatment to ask for a needle to be removed or adjusted to make me more comfortable. _____
- I understand that acupuncture treatments are allotted 1 hour from the beginning of my scheduled appointment. _____
- I understand that I have the ability to end my session sooner for any reason. _____
- I understand that each room has a bell so that if I need assistance during my treatment or when I am ready to end my treatment the acupuncturist will be able to hear me. _____
- I understand that if the acupuncturist is assisting another client it may take up to 10 minutes for them to come and assist me. _____
- I understand that if I have called for the acupuncturist and do not receive an answer within 5 minutes, I should call again and allow another few minutes as the acupuncturist may have been out of the office and did not hear me the first time. _____
- I understand that outside of the most extreme of situations it is never acceptable for a client to remove their own acupuncture needles. _____
- I understand that as a health care clinic the acupuncturist or assistant need to account for every single needle and make sure that it is properly disposed of in the safest of manors. _____
- I understand that when clients remove their own needles, naahac cannot guarantee that all needles have be disposed of safely and this poses a great health concern for all clients entering the clinic. _____