

Sarah Wergin, R.N, L.Ac.
CO License # 1036 NC #813
Kwan Yin Clinic, Inc.
North Carolina Office
828-251-4517

Informed Consent for Acupuncture

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the Oriental Medicine Practice Act, on me (or the patient named below, for whom I am legally responsible) by Sarah Wergin, R.N, L.Ac.

“Acupuncture means the use of needles inserted and removed from the human body and the use of other devices, modalities and procedures at for the prevention, cure, or correction of any disease, illness, injury, pain, or other condition by controlling or regulating the balance or flow of Qi.”

It is understood that it might take 5 to 10 treatments, at 1 to 2 treatments per week, to know whether acupuncture can help a specific condition. I understand the results are not guaranteed.

I understand there are some risks to treatment including but not limited to, bruising of the skin and/or slight bleeding. The risk of infection is very small when sterilized/disposable needles are used.

I have read, or have had read to me, the above and understand its content. By signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for present and future conditions.

Patient Name: _____
(Please Print)

Patient Signature: _____
(Or person responsible for patient, indicate relationship)

Date: _____

Office Signature: _____

Patient Information

Name: _____
Date of Birth: _____ Age: _____ Height _____ Weight _____ Sex: M ☐ F ☐
Phone: Home _____ Work: _____ Other: _____
Email: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Marital Status: S ☐ M ☐ D ☐ W ☐ Spouse Name: _____

Person Responsible for Payment if Minor: _____
Address: _____ City: _____ State: _____ Zip: _____
Person to Contact in an Emergency: _____
Day Phone: _____ Evening Phone: _____
Relationship to Patient: _____

Employment

Employer: _____ Supervisor: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____

Agreement of Financial Responsibility

I, _____ the undersigned, agree to payment as services are rendered unless prior agreement has been made in writing by Sarah Wergin, R.N, L.Ac.(Kwan Yin Clinic Inc.)

Patient billing will incur a \$10.00 per notice fee and outstanding balances will incur an 20% annual percentage rate of interest (2.0% per month) from the date of service. Patient/Responsible Party will be liable for reasonable expenses incurred by the Sarah Wergin, R.N, L.Ac.(Kwan Yin Clinic, Inc.) in enforcing the terms of this agreement including all costs of collection and attorney fees. This agreement shall be interpreted and enforced in accordance with the laws of the state of North Carolina. Sarah Wergin, R.N, L.Ac.(Kwan Yin Clinic, Inc.) has the right to waive without prejudice all fees at its sole discretion.

Concerning Insurance claims: I assume full financial responsibility for any fees I, or parties I am responsible for, have incurred at the Kwan Yin Clinic Inc./Sarah Wergin, R.N, L.Ac. that are not paid by medical insurance or any other second party, as per this agreement.

There will be a full charge for missed appointments or cancellations without 24 hours advance notice. \$45.00 will be charged for any return checks.

I hereby agree to the above statement of financial responsibility to Sarah Wergin, R.N, L.Ac. (Kwan Yin Clinic, Inc.).

Patient/Responsible Party Signature

Date



Patient Information

Name _____ Date _____

Who referred you to our clinic? (So we can thank them.) _____

Main problem you would like help with? _____

How long have you had this problem? _____

To what extent does this problem interfere with your daily activities? _____

Have you been given a diagnosis for this problem? If so, what diagnosis? _____

What other treatments have you tried, and what has been your response to those treatments?

DO YOU HAVE ANY ALLERGIES? TO WHAT?

Medical History

Please indicate if you have experienced any of the following illnesses:

____ Alcohol Addiction
____ Cancer
____ Diabetes
____ Drug Addiction
____ Food Allergies

____ Heart Disease
____ Hepatitis
____ High Blood Pressure
____ Respiratory Allergies
____ Rheumatic Fever

____ Seizures
____ Thyroid Disease
____ Venereal Disease
____ Other: _____

Diet/Lifestyle

Which of the following best describes your diet?:

- ☐ Total Vegetarian (no eggs, dairy, nor any meat of any kind)
☐ Lacto-ovo Vegetarian (diet includes vegetables and fruits plus eggs and dairy products)
☐ Semi-Vegetarian (diet includes vegetables and fruits plus eggs, dairy products, fish, and poultry)
☐ Omnivore (diet includes all foods)

Briefly describe a typical day's meals:

Breakfast: _____

Lunch: _____

Dinner: _____

Do you have any food allergies? If so, to what foods? _____

Do you diet or restrict your food intake? Explain. _____

Do you have a regular exercise program? _____

Do you smoke? If so, how much? _____

Do you drink alcoholic beverages? If so, how much per week? _____

Do you drink coffee or other caffeinated beverages? If so, how much per week? _____

Please list any medications, vitamins, or supplements you are currently taking. _____

Do you use any recreational drugs? If so, please give details. _____

Surgeries/Illnesses

Please list your past surgeries/significant illnesses and their dates:

Thank you for filling out this form.
All information is confidential.

Gynecology - Pregnancy

- ☐ Irregular Periods
- ☐ Light Flow
- ☐ PMS
- ☐ Vaginal Sores
- ☐ Abortions

- ☐ Painful Periods
- ☐ Spotting
- ☐ Vaginal Discharge
- ☐ Premature Births
- ☐ Menopausal

- ☐ Heavy Flow
- ☐ Clots
- ☐ Yeast Infections
- ☐ Miscarriages
- ☐ Postmenopausal

Age of first Menses: _____ Date of last Menses: _____ Duration of Menses: _____ days
Number of days from first day of menses to first day of next menses: _____ days.
Number of live births: _____ Complications?: _____
Method of birth control used: _____

Neuro - Psychological

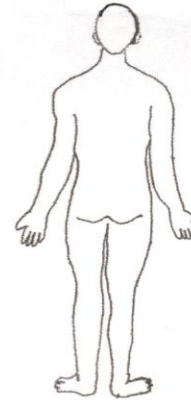
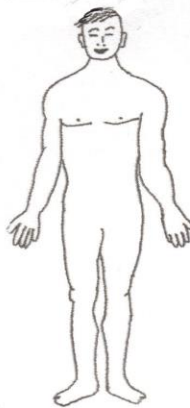
- ☐ Seizures
- ☐ Poor Memory
- ☐ Lack of Coordination
- ☐ Tremors
- ☐ Stress

- ☐ Twitches
- ☐ Irritability
- ☐ Loss of Balance
- ☐ Concussion
- ☐ Mood Swings

- ☐ Bad Temper
- ☐ Areas of body numbness
- ☐ Anxiety
- ☐ Depression
- ☐ Other: _____

Musculo - Skeletal

Indicate areas where you experience pain:



Please check which descriptions apply to your pain:

- ☐ Sharp
- ☐ Distending
- ☐ Cutting
- ☐ Heavy
- ☐ Worse in the Day
- ☐ Worse when Dry
- ☐ Aggravated by Diet

- ☐ Dull
- ☐ Cramping
- ☐ Empty
- ☐ Moving
- ☐ Worse at Night
- ☐ Worse when Hot
- ☐ Worse with Stress

- ☐ Throbbing
- ☐ Burning
- ☐ Tight
- ☐ Stabbing
- ☐ Worse when Humid
- ☐ Worse when Cold

When did you first experience discomfort or pain? _____

What was the cause of pain (if known)? _____

Anything that makes it feel worse? _____

Please check if you have experienced any of the following in the last 3 months:

General		
<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Easily Bleed or Bruise
<input type="checkbox"/> Strong Thirst	<input type="checkbox"/> Tremor	<input type="checkbox"/> Night Sweats
<input type="checkbox"/> Change in Appetite	<input type="checkbox"/> Fevers	<input type="checkbox"/> Localized Weakness
<input type="checkbox"/> Peculiar Tastes or Smells	<input type="checkbox"/> Poor Sleeping	<input type="checkbox"/> Poor Balance
<input type="checkbox"/> Cravings	<input type="checkbox"/> Puffiness or Swelling	<input type="checkbox"/> Sudden Energy Drop
<input type="checkbox"/> Sweat Easily	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Chills
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Other _____
Head, Eyes, Nose, and Throat		
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Teeth Grinding
<input type="checkbox"/> Headaches	<input type="checkbox"/> Night Blindness	<input type="checkbox"/> Nose Bleeds
<input type="checkbox"/> Glasses	<input type="checkbox"/> Ear Ringing	<input type="checkbox"/> Teeth Problems
<input type="checkbox"/> Concussions	<input type="checkbox"/> Blurry Vision	<input type="checkbox"/> Facial Pain
<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Spots in Front of Eyes	<input type="checkbox"/> Poor Vision
<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Gum Problems	<input type="checkbox"/> Eye Strain
<input type="checkbox"/> Poor Hearing	<input type="checkbox"/> Jaw Click	<input type="checkbox"/> Color Blindness
<input type="checkbox"/> Recurrent Sore Throat		
Skin and Hair		
<input type="checkbox"/> Rashes	<input type="checkbox"/> Skin Ulcers	<input type="checkbox"/> Hives
<input type="checkbox"/> Itching	<input type="checkbox"/> Eczema	<input type="checkbox"/> Pimples
<input type="checkbox"/> Dandruff	<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Recent Moles
Cardiovascular		
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cold Hands or Feet	<input type="checkbox"/> Swelling of Hands
<input type="checkbox"/> Swelling of Feet	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Blood Clots
<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Fainting	<input type="checkbox"/> Irregular Heartbeat
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Light-Headedness
Respiratory		
<input type="checkbox"/> Cough	<input type="checkbox"/> Phlegm	<input type="checkbox"/> Asthma
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Coughing up Blood	<input type="checkbox"/> Painful Breathing
<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Other: _____
Gastro-Intestinal		
<input type="checkbox"/> Nausea	<input type="checkbox"/> Bad Breath	<input type="checkbox"/> Chronic Laxative Use
<input type="checkbox"/> Blood in Stools	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Constipation
<input type="checkbox"/> Black Stools	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Rectal Pain
<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Abdominal Pain
<input type="checkbox"/> Intestinal Gas	<input type="checkbox"/> Belching	<input type="checkbox"/> Loss of Appetite
Genito-Urinary		
<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Decrease in Urine Flow	<input type="checkbox"/> Cloudy Urine
<input type="checkbox"/> Genital Sores	<input type="checkbox"/> Urgency to Urinate	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Frequent Night Urination	<input type="checkbox"/> Unable to Hold Urine
<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Herpes	

NORTH CAROLINA MANDATORY DISCLOSURE STATEMENT

Kwan Yin Clinic, Inc.
828-251-4517

Sarah Wergin, RN, LAc.
NC License #813
CO License #1036

Education and Experience

Sarah Wergin earned her Diploma of Acupuncture and Oriental Medicine in a Registered Apprenticeship in 2004. This three-year program consisted of over 4000 hours of education including Chinese herbology, moxibustion, tuina, cupping, auriculotherapy, injection therapy and dietary and lifestyle recommendations. She was certified as a Diplomat in Acupuncture by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in 2004 and received her Colorado license that same year. She is fully licensed in CO & NC. Sarah is also a Certified Functional Medicine practitioner and is a graduate from the College of St. Catherine's- Minneapolis as a Registered Nurse. She holds an active license in CO & NC.

Sarah is also a certified Mei Zen Cosmetic Acupuncture™ practitioner, Facial Soundscapes™ practitioner, Acutonics® Sound Healing practitioner, NAET Allergy and Pain Elimination practitioner and a Master Classical Feng Shui Consultant. She has also received training and certification in Western Herbalism, Healing Touch Therapy, Massage Therapy, Nutritional/Blood/Genotyping Analysis, The Eclectic Triphasic Medical System, Genetic/MTHFR therapy, Light Therapy and Akashic Record Healing.

Sarah is a member of the American Acupuncture Council. She is a licensed acupuncturist in North Carolina & Colorado and also holds an active nursing license in North Carolina & Colorado. None of Sarah's licenses, certificates, or registrations have ever been suspended or revoked. Sarah Wergin complies with the rules and regulations promulgated by the North Carolina Department of Health. All acupuncture needles are of the pre-sterilized disposable type, never used more than once, and then disposed of in approved sharps containers that are picked up by an approved hazardous waste service.

Fee Schedule

Initial Intake Consultation with Acupuncture	\$160
Established patient Acupuncture Treatment	\$95
Initial Herbal Consultation	\$120
Established patient Herbal	\$65
Initial NAET Consultation/Treatment	\$180-270
Established patient NAET Treatment	\$95 (10% series discount available)
Initial Kwan Yin Signature Treatment (Acu+Sound Healing+spiritual)	\$160-270
Established patient KY session-	\$150
Initial Functional Medicine Consultation	\$180-270
Established patient Functional Med. Consult.	\$90-180
Basic Phone Consultation (15 min increments)	\$45/15 min
Akashic Records Reading (45 min)	\$135
Classical Feng Shui Consulting (Please Inquire)	\$180/hr.
Cosmetic/Skin Rejuvenation Treatment (Please Inquire)	\$295/Follow-up \$225
SWAMI Blood/Genotype Analysis (Complete w/ take home packet)	\$495

Herbs and adjunctive therapies(cupping/gua sha/tui na/moxibustion/plaster) are an additional charge. Prices subject to change.

Patient's Rights

- The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.
- The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time.
- In a professional relationship, sexual intimacy is never appropriate and should be reported to the director of the Division of Regulations in the Department of Regulatory Agencies.

I have read and understand this document.

Patient's or Guardian's Signature

Date