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: _____

INFORMED CONSENT FOR COSMETIC ACUPUNCTURE

PATIENT NAME: _____

ACUPUNCTURIST: SARAH WERGIN, R.N., L.Ac., Sound Healer **CLINIC:** KWAN YIN CLINIC, INC.

CONSENT: I herby request and consent to Cosmetic Acupuncture treatment by the acupuncturist named above and/or other licensed acupuncturists who now, or in the future, treat me while employed by, working or associated with, or serving as back-up for, the acupuncturist named above, including those working at the clinic or office listed above or any other office or clinic whether signatories to this form or not. I understand that Cosmetic Acupuncture treatment is not a surgical procedure and is in no way intended as a substitute for cosmetic surgery.

TYPE OF CARE: I have had an opportunity to discuss with the acupuncturist named above the nature and purpose of the Cosmetic Acupuncture treatment to which I am consenting. I understand that a Cosmetic Acupuncture treatment involves the insertion of acupuncture needles to the face, neck and body, and that according to the theory of Traditional Chinese Medicine (TCM) the insertion of these needles is designed to facilitate the flow of Qi (energy) along meridians or pathways throughout the entire body. A description of the specific type of Cosmetic Acupuncture care currently contemplated follows:

Mei Zen Cosmetic Acupuncture Systems

I understand my treatment plan may be modified to address: 1) Changes in my condition, 2) Changes in my desired results, or 3) Changes in the professional standards of acupuncture care. I understand, and agree to adjustments in my treatment as needed to optimally address my well being, my objectives, and to take advantage of the full range of care options for me.

POTENTIAL BENEFITS: I understand that the purpose of Cosmetic Acupuncture is to create a younger and more vibrant appearance by properly balancing the flow of Qi. This may include enhanced skin tone, improved luster of complexion, decreased puffiness around the eyes, elimination or reduction of fine wrinkles, improved muscle tone, a firming of sagging skin, and a lessening of the visible signs of aging. However, I understand that as with all TCM care, Cosmetic Acupuncture involves a gradual, healthful process that is customized for each individual, and that individual results may vary.

NO GUARANTEE: I understand that results are not guaranteed. My questions regarding longevity of results and potential changes in my facial appearance have been answered. I understand that although good results are expected, there is no guarantee or warranty, either expressed or implied, of the results that may be obtained.

RISKS OF COSMETIC ACUPUNCTURE – I understand that every procedure involves a certain amount of risk, including Cosmetic Acupuncture. Some of the more common complications are listed immediately below. I understand and am informed that even though the majority of patients do not experience these complications, problems may arise for me:

- **BLEEDING AND BRUISING** - As with acupuncture in general, when a needle is removed, some minor bleeding may occur. This is normal and usually will not leave a bruise. Occasionally, a bruise or hematoma may appear. With bruising, it is important that you wear sunscreen when going outside. Topical and internal remedies will be discussed to address bruising. If swelling persists, I understand I should call my provider immediately.
- **Infection** – Infection at the needle site is very rare after an acupuncture treatment because the needles are sterile. If you suspect infection at the needling site (i.e. redness, swelling or warm to touch), call me. Additional treatment or referral to your M.D. may be necessary.
- **DAMAGE TO DEEPER STRUCTURES** – In certain systems, deeper structures such as blood vessels, nerves and muscles are rarely damaged during the course of a Cosmetic Acupuncture treatment. If this does occur, the injury may be temporary or permanent.
- **ASYMMETRY** – All facial structures are naturally asymmetrical. Results may vary from side to side due to the natural asymmetry, previous injuries on one side of the body, or severity of symptoms from one side or the other.
- **NERVE INJURY** –Injury to the motor or sensory nerve very rarely results from facial acupuncture treatments. Nerve injuries may cause temporary or permanent loss of facial movements and feeling. Such injuries may improve over time. Injury to the sensory nerves of the face, neck and ear regions may cause temporary or, more rarely, permanent numbness. Painful nerve scarring is extremely rare.
- **NEEDLE SHOCK** – Needle shock is a rare complication that can happen during any acupuncture treatment. If I feel faint or shaky during the treatment, I understand I should notify my provider immediately.

TURN OVER PLEASE

- **ALLERGIC REACTION** – In rare cases, local allergies to topical preparations have been reported. Systemic reactions that are more serious may occur to herbs used during an acupuncture treatment. Skin testing is done prior to application of any herbal preparations. Allergic reactions may require additional treatment or discontinuation of treatment.
- **DELAYED HEALING** – Delayed healing is a rare complication. Smoking and certain health conditions such as diabetes, chronic fatigue syndrome, to name a few, may delay the healing response of any of the aforementioned risks.
- **UNSATISFACTORY RESULTS** – I understand that I am not having a surgical procedure. The alternatives, risks, and comparisons of surgical procedures versus acupuncture have been discussed with me and outlined in this document. Should I have any further questions, I will discuss them with my provider before treatment begins.
- **LONG TERM EFFECTS** - Following Cosmetic Acupuncture treatments, changes in facial appearance may occur as the result of the normal process of aging, weight loss or gain, sun exposure, stress, illness, or other circumstances not related to acupuncture. It has been explained that following lifestyle and dietary instructions may enhance the longevity of the Cosmetic Acupuncture treatment while non-compliance will adversely affect the longevity of the Cosmetic Acupuncture treatment. Additional, future treatments may be necessary to maintain the results.
- **UNFORESEEABLE IMPACTS** - There are many variable conditions, in addition to the risks and potential complications enumerated, that may influence the long term result from Cosmetic Acupuncture treatments. While the complications cited are the ones particularly associated with Cosmetic Acupuncture treatments, the practice of acupuncture is not an exact science, and other less common complications may arise. Should these or other complications occur, other treatments may be necessary.

ALTERNATIVE TREATMENT – I understand that other alternatives exist for cosmetic care including but not limited to surgery, such as a surgical facelift, chemical face peels, or liposuction. I realize that there are also risks and potential complications associated with these alternative forms of treatment.

HEALTH INSURANCE / FINANCIAL RESPONSIBILITY - I understand that most health insurance does not cover the cost of the Cosmetic Acupuncture treatments or complications resulting from such treatments. Please contact your insurance if you have any questions about coverage. Depending on whether any or all of the cost of Cosmetic Acupuncture is covered by an insurance plan, I will be responsible for charges not so covered.

UNFORESEEN CONDITIONS – I understand that there are several styles or methods of facial, cosmetic, or rejuvenation acupuncture and have been informed that that during the course of Cosmetic Acupuncture treatments, unforeseen conditions may necessitate different procedures than those listed above.

AGREEMENT AND CONTINUOUS EFFECT: I have read, or have had read to me, the above consent. It has been explained to me in a way that I understand: a) The risks involved with Cosmetic Acupuncture, b) That I have alternatives available to me for cosmetic improvements, and c) What protocols will be used in connection with treatment. I have also had an opportunity to ask questions about the Cosmetic Acupuncture, and am satisfied that all my questions have been answered. I acknowledge that no guarantee has been given to me by anyone as to the results that may be obtained. I authorize the release of medical information, when required. Finally, by signing below I acknowledge that I have been fully informed about, and agree to, Cosmetic Acupuncture treatments. 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 SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

OFFICE SIGNATURE **X**

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

KWAN YIN CLINIC, INC.

Patient Information

Cosmetic Acupuncture/Facial Soundscapes™

Name_____ Date_____

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

What are the skin areas you would like to work on?

_____

_____

What are the results you are expecting from Cosmetic Acupuncture or Facial Soundscapes?

_____

_____

What do you ***not*** like about your skin? _____

_____

What do you love about your skin? _____

_____

Do you have a skincare regimen? If so, what do you use?

_____

_____

Do you have any skin problems that have been diagnosed?_____

What other treatments have you tried and what were the results?_____

_____

Do you have any implants of any kind?_____

_____

DO YOU HAVE ANY ALLERGIES? TO WHAT? _____

_____

_____

_____

_____

Medical History

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

____ Alcohol Addiction	____ Heart Disease	____ Seizures
____ Cancer	____ Hepatitis	____ Thyroid Disease
____ Diabetes	____ High Blood Pressure	____ Venereal Disease
____ Drug Addiction	____ Respiratory Allergies	____ Other: _____
____ Food Allergies	____ Rheumatic Fever	_____

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?: _____

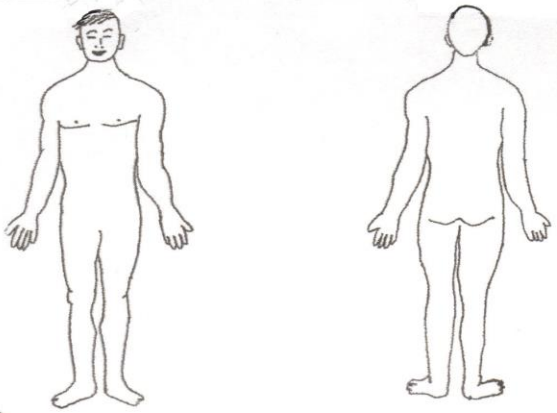
Method of birth control used: _____

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

- ☐ Poor Appetite
- ☐ Strong Thirst
- ☐ Change in Appetite
- ☐ Peculiar Tastes or Smells
- ☐ Cravings
- ☐ Sweat Easily
- ☐ Weight Loss
- ☐ Hearing Loss
- ☐ Tremor
- ☐ Fevers
- ☐ Poor Sleeping
- ☐ Puffiness or Swelling
- ☐ Fatigue
- ☐ Weight Gain
- ☐ Easily Bleed or Bruise
- ☐ Night Sweats
- ☐ Localized Weakness
- ☐ Poor Balance
- ☐ Sudden Energy Drop
- ☐ Chills
- ☐ Other _____

Head, Eyes, Nose, and Throat

- ☐ Dizziness
- ☐ Headaches
- ☐ Glasses
- ☐ Concussions
- ☐ Eye Pain
- ☐ Sinus Problems
- ☐ Poor Hearing
- ☐ Recurrent Sore Throat
- ☐ Cataracts
- ☐ Night Blindness
- ☐ Ear Ringing
- ☐ Blurry Vision
- ☐ Spots in Front of Eyes
- ☐ Gum Problems
- ☐ Jaw Click
- ☐ Teeth Grinding
- ☐ Nose Bleeds
- ☐ Teeth Problems
- ☐ Facial Pain
- ☐ Poor Vision
- ☐ Eye Strain
- ☐ Color Blindness

Skin and Hair

- ☐ Rashes
- ☐ Itching
- ☐ Dandruff
- ☐ Skin Ulcers
- ☐ Eczema
- ☐ Hair Loss
- ☐ Hives
- ☐ Pimples
- ☐ Recent Moles

Cardiovascular

- ☐ High Blood Pressure
- ☐ Swelling of Feet
- ☐ Phlebitis
- ☐ Palpitations
- ☐ Cold Hands or Feet
- ☐ Low Blood Pressure
- ☐ Fainting
- ☐ Chest Pain
- ☐ Swelling of Hands
- ☐ Blood Clots
- ☐ Irregular Heartbeat
- ☐ Light-Headedness

Respiratory

- ☐ Cough
- ☐ Bronchitis
- ☐ Difficulty Breathing
- ☐ Phlegm
- ☐ Coughing up Blood
- ☐ Pneumonia
- ☐ Asthma
- ☐ Painful Breathing
- ☐ Other:_____

Gastro-Intestinal

- ☐ Nausea
- ☐ Blood in Stools
- ☐ Black Stools
- ☐ Hemorrhoids
- ☐ Intestinal Gas
- ☐ Bad Breath
- ☐ Indigestion
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Belching
- ☐ Chronic Laxative Use
- ☐ Constipation
- ☐ Rectal Pain
- ☐ Abdominal Pain
- ☐ Loss of Appetite

Genito-Urinary

- ☐ Painful Urination
- ☐ Genital Sores
- ☐ Kidney Stones
- ☐ Blood in Urine
- ☐ Decrease in Urine Flow
- ☐ Urgency to Urinate
- ☐ Frequent Night Urination
- ☐ Herpes
- ☐ Cloudy Urine
- ☐ Frequent Urination
- ☐ Unable to Hold Urine

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 then 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