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

NAET Consent and Release Form

Sarah Wergin, R.N, L.Ac.-KWAN YIN CLINIC, INC.
North Carolina Office 828-251-4517

I _____ certify that Sarah Wergin, R.N., L.Ac. does not claim to cure my illness or disease with NAET (Nambudripad's Allergy Elimination Technique).

I understand that NAET is not a medical diagnostic procedure and therefore does not diagnose a disease. Rather, NAET gives the practitioner an indication as to the substance(s) to which the patient may have a sensitivity. NAET uses various, standard medically proven diagnostic measures and modalities (Allopathic, Chiropractic, Kinesiological, and Acupuncture) to diagnose the patient's condition. The premise behind NAET is to desensitize a patient to a substance(s) using allopathic, chiropractic, acupuncture/acupressure, nutritional and kinesiological principles so that the patient may not experience hypersensitive symptoms when they have future contact with them.

I understand that I am (my dependant) to continue all medications and other treatment modalities as they are prescribed unless otherwise directed by the doctor who prescribed them. During the 25 hours or after if I (my dependant) get a life-threatening reaction from the allergen I (my dependent) was treated for or from some other source, I need to seek emergency help immediately from a physician qualified in emergency treatments, or by calling 911 or attending an emergency room at the local hospital. If I (my dependent) am suffering from severe allergic reaction to substances, I should consult an appropriate physician and take appropriate medication (such as medication to prevent itching, tissue swelling, fever, cough, pains, infections, mental irritability, violent behaviors, etc.) to keep my (my dependent's) symptoms under control while I (my dependent) am treating with NAET treatments. This way essential NAET treatments can be completed without interruption and once I (my dependent) complete the essential NAET treatments for my (my dependent's) condition, I (my dependent) may not need to continue pharmaceutical drugs indefinitely.

I understand that for 25 hours after the treatment I (my dependent) am to avoid eating, touching, breathing or coming within 5 feet or more as it was instructed by my practitioner of the substance(s) that I (my dependent) may have received treatment for. If I (my dependent) come into contact with the substance in which I (my dependent) am being treated, I realize that the treatment may not work and I (my dependent) may have a sensitivity reaction.

I understand that I (my dependent) must return after my 25 hour avoidance period preferably within 24 hours but at least within 7 days, to see if I (my dependent) have cleared for the substance(s). I fully understand that I (my dependent) may still experience a reaction to the substance(s) of unknown severity if I (my dependent) did not clear them completely, I (my dependent) may require to repeat the procedure (more office visits at my cost) until I (my dependent) clear them satisfactorily.

I give permission to the KWAN YIN CLINIC, INC. & Sarah Wergin to use my (my ward's) case study in educating other similar patients or accumulating data for research purpose without disclosing my real name or address. I give permission to take photographs of my (my ward's) diseased body part to use in research or patient education purpose without disclosing my real name or address.

I have read or have had read to me the above statements and have had the opportunity to ask questions about its content and by signing below I agree to the terms and procedures.

Signature_____Date_____

Witness_____Date_____

KWAN YIN CLINIC, INC.

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 illesses 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?: _____

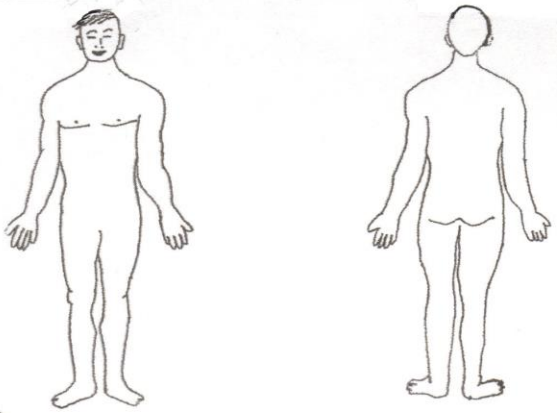
Method of birth control used: _____

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