



UPDATED 2026 - COMPREHENSIVE CLINICAL MODALITIES DISCLOSURE & CONSENT

Patient Initial & Acknowledgement Form for Clinic Records

Patient Name: _____ DOB: _____
Guardian Name (if patient is under 18): _____

Date: _____ Provider Name: All licensed professionals at AWS

INSTRUCTIONS FOR PATIENT

Please read each section carefully. This document outlines the scope, legal boundaries, risk profiles, and non-medical nature of all services provided in our office by licensed members of our **Acupuncture and Esthetics teams** under New York State law. **Please place your initials in the bracket provided next to EACH statement to acknowledge your understanding.**

1. NO MEDICAL CLAIMS & SOLE PURPOSE OF CARE

1. [____] **No Claims to Cure or Treat Medical Conditions:** I explicitly acknowledge and agree that practitioners, staff, and representatives in this office do **NOT** claim, state, or represent that any therapy, modality, protocol, or product provided can diagnose, treat, cure, heal, or prevent any physical or Western medical disease, illness, condition, or ailment of the body, **including, but not limited to**, acute or chronic illnesses, metabolic disorders, autoimmune conditions, or infectious diseases.
2. [____] **Sole Objective of Treatments:** I understand that the **sole purpose and objective** of all services provided by the acupuncture and esthetics team is to promote general wellness, support the body's natural capacity for balance, and correct energetic disturbances or blockages strictly within the lawful scope of state licensure.

2. NO GUARANTEE OF RESULTS OR OUTCOMES

3. [____] **Variable Individual Responses:** I understand that human physiology, health history, lifestyle, and bio-energetic responses vary significantly from person to person. While all procedures are performed with professional care and skill, **no promise, guarantee, or warranty** is made regarding specific health outcomes, treatment success, or the resolution of any particular symptom, complaint, or condition, **including, but not limited to**, pain relief, skin improvements, energetic alignment, or symptom reduction.



4. [____] **Service-Based Care:** I acknowledge that clinical fees cover the practitioner's professional time, expertise, equipment usage, and administration of modalities. I understand that lack of desired results or non-resolution of symptoms does not constitute a breach of standard care or grounds for a refund.

3. USE OF MEDICAL TERMINOLOGY & ENERGETIC CONTEXT

5. [____] **Energetic Context of Western Terms:** I acknowledge that if practitioners or staff mention terms commonly associated with Western medicine—including, **but not limited to**, specific *infections, hormone imbalances, diseases, syndromes, organ dysfunction, or biological elements*—these references are used **strictly in an energetic, metaphorical, or East Asian medical context**.
6. [____] **Focus on Wellness & Symptom Support:** I understand that references to such terms are intended solely to address energetic disharmony, support overall systemic balance, and promote comfort regarding symptoms associated with those words, and do **not** constitute a formal medical diagnosis or identification of clinical pathology.

4. RISKS OF ACUPUNCTURE & ALL CLINICAL/ESTHETIC MODALITIES

7. [____] **General Risks of Acupuncture:** I understand that acupuncture is generally safe, but carries potential risks, **including, but not limited to**, temporary soreness, minor bleeding, bruising, local swelling, lightheadedness, or rare fainting. Extremely rare risks include needle breakage, infection at the needle site, nerve irritation, or organ puncture (e.g., pneumothorax). Single-use, sterile, disposable needles are always utilized to minimize infection risks.
8. [____] **Risks of Manual Therapies (Cupping & Gua Sha):** I understand that Cupping and Gua Sha involve suction and friction, which intentionally produce red, purple, or dark petechiae/bruising that can last from 3 to 10 days. Potential side effects include, **but are not limited to**, mild skin sensitivity, temporary soreness, skin irritation, or blister formation (rare).
9. [____] **Risks of Auricular & Microcurrent Modalities:** I understand that Auricular Therapy (ear seeds, tacks, or needles) carries risks, **including, but not limited to**, localized cartilage tenderness, skin irritation, or minor infection if kept wet or uncleaned. Microcurrent and LED light therapy carry minimal risks, **including, but not limited to**, skin tingling, mild headache, temporary dryness, light sensitivity, or mild redness.
10. [____] **Risks of Ingestibles (Herbs & Supplements):** I understand that Chinese herbal formulas and dietary supplements may cause mild side effects, **including, but not limited to**, nausea, gas, bloating, loose stools, digestive upset, headache, or allergic skin reactions. Rare adverse reactions may occur, including organ strain or medication interactions, if full medical histories are not disclosed.



11. [____] **Risks of Bio-Energetic Testing & Desensitization (Zyto, NAET, SAAT, Vials):** I understand that Zyto scans, energy vial testing, NAET, and SAAT are non-invasive, but energetic balancing protocols may trigger temporary "healing responses" or detox-like feelings, **including, but not limited to**, fatigue, emotional releases, temporary flare-ups of pre-existing symptoms, lightheadedness, or mild headache as the body recalibrates.
12. [____] **Risks of Esthetics & Facial Rejuvenation Procedures:** I understand that facial rejuvenation, cosmetic acupuncture, non-ablative facial treatments, and skin care procedures carry risks, **including, but not limited to**, mild redness, localized swelling, temporary skin dryness, post-treatment sensitivity, or small facial bruising.

5. BIO-ENERGETIC TESTING (MRT, VIALS, ZYTO BIO-RESONANCE)

13. [____] **Qualitative Assessment:** I understand that Muscle Response Testing (MRT), test vials, and the **Zyto Bio-Resonance Scanner** are non-invasive, qualitative feedback tools used solely to measure galvanic skin response, energetic stress, and *Qi* balance.
14. [____] **Non-Diagnostic Nature:** I acknowledge that Zyto scans, energy vials, and muscle testing **do not** measure physical blood levels, diagnose medical conditions, detect systemic infections, or replace standard clinical laboratory diagnostics.
15. [____] **Meaning of Stress Markers:** I understand that "stressors," "weaknesses," or positive responses to vials/scans represent bio-energetic imbalances in my system's frequency field regarding that specific substance frequency—**including, but not limited to**, foods, hormones, environmental factors, or micro-organisms—and **do not** indicate an active medical illness, pathology, or infectious disease.

6. ALLERGY SENSITIVITY PROTOCOLS (NAET & SAAT)

16. [____] **Scope of NAET & SAAT:** I understand that Nambudripad's Allergy Elimination Techniques (NAET) and Soliman Auricular Allergy Treatment (SAAT) are specialized acupuncture and bio-energetic protocols designed to unblock meridian stasis and reprogram neuro-energetic reactivity.
17. [____] **Severe Allergies & Anaphylaxis:** I acknowledge that NAET and SAAT **are not** Western medical allergy treatments or IgE blood/skin tests. They do not eliminate the risk of life-threatening anaphylaxis. I agree to retain any prescribed emergency epinephrine (EpiPen) and seek emergency medical care if exposed to severe allergens.

7. CHINESE HERBAL MEDICINE & DIETARY SUPPLEMENTS

18. [____] **Functional & Energetic Support:** I understand that Chinese herbal formulas and dietary supplements recommended in this office are used to support overall body balance, *Qi*, *Blood*, and organ network harmony under traditional Asian medicine principles, not to cure Western diseases.
19. [____] **Safety & Disclosures:** I agree to disclose all current prescription medications, over-the-counter drugs, allergies, and health conditions (**including, but not limited to**, pregnancy or nursing) prior to taking any herbs or supplements. I agree to take all products strictly as directed.



20. [____] **Side Effects & Interaction Risks:** I understand that natural products may occasionally cause mild adverse effects (**including, but not limited to**, digestive upset, rash) or interact with medications. I agree to discontinue use and notify the clinic immediately if I experience unwanted symptoms.

8. EAST ASIAN MANUAL THERAPIES (CUPPING, GUA SHA, AURICULAR)

21. [____] **Cupping & Gua Sha Expectations:** I understand that Cupping (vacuum suction) and Gua Sha (friction scraping) are used to promote circulation and relieve muscle tension. I explicitly consent to the temporary red, purple, or dark discoloration (petechiae/bruising) that typically lasts 3 to 10 days post-treatment.
22. [____] **Auricular Therapy:** I understand that Auricular Therapy (ear needling, ear seeds, or press tacks) stimulates reflex points on the outer ear. I agree to notify the clinic if I experience localized soreness or irritation, and to clean or remove ear seeds/tacks as instructed.

9. ESTHETICS & NON-INVASIVE FACIAL REJUVENATION

23. [____] **Scope of Esthetic Care:** I understand that facial rejuvenation, cosmetic acupuncture, microcurrent, LED light therapy, non-ablative facial treatments, and skin care procedures performed by our licensed acupuncture and esthetic team are strictly non-invasive cosmetic treatments intended to enhance skin appearance and muscle tone.
24. [____] **No Medical/Surgical Claims:** I acknowledge that esthetic procedures provided here **do not** include medical-dermatological procedures, invasive surgical face-lifts, deep chemical peels, or pharmaceutical injectables (**including, but not limited to**, Botox or dermal fillers).
25. [____] **Skin Reactions & Care:** I understand that temporary skin reactions (**including, but not limited to**, redness, mild warmth, slight sensitivity, or minor swelling) may occur following facial rejuvenation protocols. I agree to follow all post-treatment care instructions, including sun protection.

10. INTEGRATIVE CARE & RESPONSIBILITIES

26. [____] **Primary Care Relationship:** I acknowledge that the practitioners in this office act within their specific licensed scopes (Acupuncture / Esthetics) and do not serve as my primary care physician or medical specialist.
27. [____] **Medication Continuity:** I agree that I will not discontinue, alter, or delay taking any prescribed Western medical medications or treatments based on evaluations, scans, or recommendations received in this clinic without consulting my prescribing physician.
28. [____] **Voluntary Consent:** I confirm that I have read this document, have had all my questions answered satisfactorily, and voluntarily consent to receive these evaluations, therapies, and care protocols from the acupuncture and esthetics team.



PATIENT SIGNATURE & ACKNOWLEDGEMENT

By signing below, I certify that I have read, understood, and individually initialed all twenty-eight (28) points above. I acknowledge that a copy of this form will be permanently scanned and retained in my electronic health record.

Patient

Signature: _____ **Date:** _____

Printed

Name: _____

Practitioner/Witness

Signature: _____ **Date:** _____