



**An Integrated Health Resource**

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**Client Information**

Today's Date: \_\_\_\_\_

(Please print)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Office Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_

Age: \_\_\_\_\_ Birth date: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**Notice of Understanding and Agreement**

I understand that I am not receiving consultation for medical diagnosis or medical treatment procedures. The services performed at this clinic are for the purpose of helping me gain a better understanding of my level of health so that I will have a greater self-awareness and be able to use a self-care program.

I understand that the recommendations, discussion, sale of nutritional supplements or homeopathics pertain to the "whole body" energetic concept of nutrition and do not relate to the treatment of any specific ailment or condition.

The appointments do not involve diagnosis, prognostication, treatment or prescription of medicines for illness or disease, or any act which will constitute the practice of medicine in the state of Georgia.

I (we) agree to pay for services rendered as the charge is incurred.

**Cancellation Policy**

In order to best accommodate your requests, we ask that a minimum notice of 24 hours be given for any changes or cancellation. Cancellations of less than 24 hours will be charged a fee equivalent to half the scheduled service total. We regret that lack of any notification will result in full billing of your scheduled services.

**Consent for a Minor or Dependant (if applicable)**

I do hereby give my full authority and consent to the staff at Quintessential Health Care to assist the client mentioned below in a self-care program.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Spouse or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_