Perfect Balance
Natural Health
166 Pelham Commons Blvd.
Greenville, SC 29615
(864) 236-8072

Dear New Client:

Thank you for making an appointment with Perfect Balance Natural Health. We look forward to working with you toward great health. We work with each client on an individual basis. Your health is very specific to you. In order to do this, we must get to know you, your history and your health goals.

Enclosed is a packet of information including:

- Information packet on you – it is especially important that we know as much about you as possible. All information is kept completely private. Please complete this form **BEFORE** coming for your visit.
- HIPAA form – please read and sign.
- Liability Waiver – please read and sign.
- Instructions on preparation for your first visit – please be sure to fast for 6 hours prior to your first visit as directed on this instruction form.

The initial appointment for all ages will last 1 1/2 – 2 hours and cost $380.00. Please bring your current supplements so we can test them to see how well your body is utilizing them. You will also be advised regarding any additional supplements that may be required to meet your specific physical needs. We sell these supplements in our office. The additional charge for the supplements could range from $150 - $300, depending on your health issues.

Follow up visits may include:

- Allergen clearings – 45 minutes - $102.00
- Advanced energetic work – maybe more than 45 minutes and will be charged according to the time required.

As insurance does not cover this type of alternative health care, please be prepared to pay for the visit and supplements at the time of your visit. For your convenience, we accept cash, check, AmEx, Visa, MC and Discover.

We realize that health care is costly. However, we have also found from personal experience that it is far more expensive to be sick (including deductible costs, time off work, medicines, side effects from medicine and/or surgery and time lost enjoying life). We trust you will find your expense at being healthy worth the time and money involved.

Please feel free to call regarding any questions you may have.

Sincerely,

Barbara Morris, RN, BS

HIPAA NOTICE OF PRIVACY PRACTICES

_____Name

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you or to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, training of students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to students who see clients in our office. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration Requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, Required Uses and Disclosures, Under the Law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made Only with Your Consent, Authorization or Opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before October 1, 2005.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

_____Signature ____ _____Date

Perfect Balance
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Greenville, SC 29615
(864) 236-8072

INSTRUCTIONS FOR YOUR NEW CLIENT EVALUATION:

1. Please come in fasting for your first visit. Fasting means no food. Please drink water to stay hydrated. For adults this means no food for **6** hours, for children 8-12 years old, no food for **4** hours and for children 7 years and younger, no fasting is necessary. For pregnant and nursing mothers, fast as long as you can and remain comfortable.

2. Please bring all medications, vitamins, enzymes and supplements you are currently taking. You may continue to take your medications as usual prior to your appointment.

3. Please bring a snack to be eaten after initial fasting testing is complete. The snack should contain carbohydrate, protein, sugar and fiber (i.e. Protein bar, trail mix or a peanut butter sandwich).

4. **Please bring in your completed paperwork.**

5. Please **do not** wear perfume or fragrance. We see many sensitive clients at our office.

If you have questions, please feel free to contact my office at 864-236-8072

Perfect Balance Natural Health

Informed Consent Barbara Morris

I understand Barbara Morris is a licensed registered nurse and is allowed to help me improve my own physical, mental, emotional and spiritual sickness that is manifesting in my life defined by the scope of practice of her registration. I also understand that Barbara Morris will not diagnose, treat or cure those issues, diseases, disorders or conditions.

I further understand that Barbara Morris is a Certified Bioset Practitioner who uses biofeedback to help me improve my peak performance in my work, hobbies and other facets of my life.

I understand that I am responsible for my own health, healing and well being. I understand natural healing is not a substitute for additional medical care and I intend to utilize the care of my primary healthcare provider as I deem necessary.

I understand all healing may cause me some minor discomfort and some adverse side effects may occur through no fault of myself or Barbara Morris. I also understand some interventions are contraindicated by the manufacturer and I will be fully advised of these contraindications. I further understand these services may have no effect on me.

I will keep Barbara Morris fully advised about my concerns so the intervention may be terminated if necessary or revised to minimize any harm to me.

I understand that my health and healing is my responsibility; and I choose to use the natural healing services of Barbara Morris to help me heal and improve my health.

I understand Barbara Morris will keep all information she learns about me completely confidential unless I release her in writing or as required by law.

I understand my identity and any information about me, whether I share it with Barbara Morris or she discovers it on her own, will be held in the strictest confidence, except when released by me or specifically required by law. I have the right to waive this confidentiality agreement in whole or part at any time.

I also understand that all revealed information about possible felonies or threats of suicide or harm to other human beings will be reported as dictated by the law.

I agree to settle any disagreements I have with Barbara Morris and if this is not possible, then I agree to turn our concerns over to The Natural Therapies Conflict Resolution Services to mediate an agreement acceptable to both myself and Barbara Morris.

I acknowledge that I have read and understand this form. I agree to allow Barbara Morris to help me learn to heal myself using the natural healing techniques and modalities herein listed.

Name of Client _____
Address _____
State/Province _____ Postal Code _____
Signature _____ Date _____
Name if other than client _____
Relationship to client _____

Perfect Balance Natural Health

Informed Consent Keith Williamson

I understand that Keith Williamson is a Certified Natural Health Practitioner and is allowed to help me improve my own physical, mental, emotional and spiritual sickness that is manifesting in my life defined by the scope of practice of his certification. I also understand that Keith Williamson will not diagnose, treat or cure those issues, diseases, disorders or conditions.

I further understand that Keith Williamson uses biofeedback to help me improve my peak performance in my work, hobbies and other facets of my life.

I understand that I am responsible for my own health, healing and well being. I understand natural healing is not a substitute for additional medical care and I intend to utilize the care of my primary healthcare provider as I deem necessary.

I understand all healing may cause me some minor discomfort and some adverse side effects may occur through no fault of myself or Keith Williamson. I also understand some interventions are contraindicated by the manufacturer and I will be fully advised of these contraindications. I further understand these services may have no effect on me.

I will keep Keith Williamson fully advised about my concerns so the intervention may be terminated if necessary or revised to minimize any harm to me.

I understand that my health and healing is my responsibility; and I choose to use the natural healing services of Keith Williamson to help me heal and improve my health.

I understand Keith Williamson will keep all information he learns about me completely confidential unless I release him in writing or as required by law.

I understand my identity and any information about me, whether I share it with Keith Williamson or he discovers it on his own, will be held in the strictest confidence, except when released by me or specifically required by law. I have the right to waive this confidentiality agreement in whole or part at any time.

I also understand that all revealed information about possible felonies or threats of suicide or harm to other human beings will be reported as dictated by the law.

I agree to settle any disagreements I have with Keith Williamson and if this is not possible, then I agree to turn our concerns over to The Natural Therapies Conflict Resolution Services to mediate an agreement acceptable to both myself and Keith Williamson.

I acknowledge that I have read and understand this form. I agree to allow Keith Williamson to help me learn to heal myself using the natural healing techniques and modalities herein listed.

Name of Client _____
Address _____
State/Province _____ Postal Code _____
Signature _____ Date _____
Name if other than client _____
Relationship to client _____

Perfect Balance Natural Health

Informed Consent Kathleen Martin

I understand that Kathleen Martin is a Certified Natural Health Practitioner and is allowed to help me improve my own physical, mental, emotional and spiritual sickness that is manifesting in my life defined by the scope of practice of her certification. I also understand that Kathleen Martin will not diagnose, treat or cure those issues, diseases, disorders or conditions.

I further understand that Kathleen Martin uses biofeedback to help me improve my peak performance in my work, hobbies and other facets of my life.

I understand that I am responsible for my own health, healing and well being. I understand natural healing is not a substitute for additional medical care and I intend to utilize the care of my primary healthcare provider as I deem necessary.

I understand all healing may cause me some minor discomfort and some adverse side effects may occur through no fault of myself or Kathleen Martin. I also understand some interventions are contraindicated by the manufacturer and I will be fully advised of these contraindications. I further understand these services may have no effect on me.

I will keep Kathleen Martin fully advised about my concerns so the intervention may be terminated if necessary or revised to minimize any harm to me.

I understand that my health and healing is my responsibility; and I choose to use the natural healing services of Kathleen Martin to help me heal and improve my health.

I understand Kathleen Martin will keep all information she learns about me completely confidential unless I release her in writing or as required by law.

I understand my identity and any information about me, whether I share it with Kathleen Martin or she discovers it on her own, will be held in the strictest confidence, except when released by me or specifically required by law. I have the right to waive this confidentiality agreement in whole or part at any time.

I also understand that all revealed information about possible felonies or threats of suicide or harm to other human beings will be reported as dictated by the law.

I agree to settle any disagreements I have with Kathleen Martin and if this is not possible, then I agree to turn our concerns over to The Natural Therapies Conflict Resolution Services to mediate an agreement acceptable to both myself and Kathleen Martin.

I acknowledge that I have read and understand this form. I agree to allow Kathleen Martin to help me learn to heal myself using the natural healing techniques and modalities herein listed.

Name of Client _____
Address _____
State/Province _____ Postal Code _____
Signature _____ Date _____
Name if other than client _____
Relationship to client _____

Perfect Balance Natural Health

Informed Consent Tricia Robinson

I understand Tricia Robinson is a Certified Natural Health Practitioner and is allowed to help me improve my own physical, mental, emotional and spiritual sickness that is manifesting in my life defined by the scope of practice of her registration. I also understand that Tricia Robinson will not diagnose, treat or cure those issues, diseases, disorders or conditions.

I further understand that Tricia Robinson is a Certified Bioset Practitioner who uses biofeedback to help me improve my peak performance in my work, hobbies and other facets of my life.

I understand that I am responsible for my own health, healing and well being. I understand natural healing is not a substitute for additional medical care and I intend to utilize the care of my primary healthcare provider as I deem necessary.

I understand all healing may cause me some minor discomfort and some adverse side effects may occur through no fault of myself or Tricia Robinson. I also understand some interventions are contraindicated by the manufacturer and I will be fully advised of these contraindications. I further understand these services may have no effect on me.

I will keep Tricia Robinson fully advised about my concerns so the intervention may be terminated if necessary or revised to minimize any harm to me.

I understand that my health and healing is my responsibility; and I choose to use the natural healing services of Tricia Robinson to help me heal and improve my health.

I understand Tricia Robinson will keep all information she learns about me completely confidential unless I release her in writing or as required by law.

I understand my identity and any information about me, whether I share it with Tricia Robinson or she discovers it on her own, will be held in the strictest confidence, except when released by me or specifically required by law. I have the right to waive this confidentiality agreement in whole or part at any time.

I also understand that all revealed information about possible felonies or threats of suicide or harm to other human beings will be reported as dictated by the law.

I agree to settle any disagreements I have with Tricia Robinson and if this is not possible, then I agree to turn our concerns over to The Natural Therapies Conflict Resolution Services to mediate an agreement acceptable to both myself and Tricia Robinson.

I acknowledge that I have read and understand this form. I agree to allow Tricia Robinson to help me learn to heal myself using the natural healing techniques and modalities herein listed.

Name of Client _____
Address _____
State/Province _____ Postal Code _____
Signature _____ Date _____
Name if other than client _____
Relationship to client _____

Perfect Balance Natural Health

Informed Consent Tamara Preston

I understand Tamara Preston is Certified Natural Health Practitioner and is allowed to help me improve my own physical, mental, emotional and spiritual sickness that is manifesting in my life defined by the scope of practice of her registration. I also understand that Tamara Preston will not diagnose, treat or cure those issues, diseases, disorders or conditions.

I further understand that Tamara Preston is a Practitioner who uses biofeedback to help me improve my peak performance in my work, hobbies and other facets of my life.

I understand that I am responsible for my own health, healing and wellbeing. I understand natural healing is not a substitute for additional medical care and I intend to utilize the care of my primary healthcare provider as I deem necessary.

I understand all healing may cause me some minor discomfort and some adverse side effects may occur through no fault of myself or Tamara Preston. I also understand some interventions are contraindicated by the manufacturer and I will be fully advised of these contraindications. I further understand these services may have no effect on me.

I will keep Tamara Preston fully advised about my concerns so the intervention may be terminated if necessary or revised to minimize any harm to me.

I understand that my health and healing is my responsibility; and I choose to use the natural healing services of Tamara Preston to help me heal and improve my health.

I understand Tamara Preston will keep all information she learns about me completely confidential unless I release her in writing or as required by law.

I understand my identity and any information about me, whether I share it with Tamara Preston or she discovers it on her own, will be held in the strictest confidence, except when released by me or specifically required by law. I have the right to waive this confidentiality agreement in whole or part at any time.

I also understand that all revealed information about possible felonies or threats of suicide or harm to other human beings will be reported as dictated by the law.

I agree to settle any disagreements I have with Tamara Preston and if this is not possible, then I agree to turn our concerns over to The Natural Therapies Conflict Resolution Services to mediate an agreement acceptable to both myself and Tamara Preston.

I acknowledge that I have read and understand this form. I agree to allow Tamara Preston to help me learn to heal myself using the natural healing techniques and modalities herein listed.

Name of Client _____
Address _____
State/Province _____ Postal Code _____
Signature _____ Date _____
Name if other than client _____
Relationship to client _____

Perfect Balance Natural Health

Informed Consent Nancy Estelle

I understand Nancy Estelle is Certified Natural Health Practitioner and is allowed to help me improve my own physical, mental, emotional and spiritual sickness that is manifesting in my life defined by the scope of practice of her registration. I also understand that Nancy Estelle will not diagnose, treat or cure those issues, diseases, disorders or conditions.

I further understand that Nancy Estelle is a Practitioner who uses biofeedback to help me improve my peak performance in my work, hobbies and other facets of my life.

I understand that I am responsible for my own health, healing and wellbeing. I understand natural healing is not a substitute for additional medical care and I intend to utilize the care of my primary healthcare provider as I deem necessary.

I understand all healing may cause me some minor discomfort and some adverse side effects may occur through no fault of myself or Nancy Estelle. I also understand some interventions are contraindicated by the manufacturer and I will be fully advised of these contraindications. I further understand these services may have no effect on me.

I will keep Nancy Estelle fully advised about my concerns so the intervention may be terminated if necessary or revised to minimize any harm to me.

I understand that my health and healing is my responsibility; and I choose to use the natural healing services of Nancy Estelle to help me heal and improve my health.

I understand Nancy Estelle will keep all information she learns about me completely confidential unless I release her in writing or as required by law.

I understand my identity and any information about me, whether I share it with Nancy Estelle or she discovers it on her own, will be held in the strictest confidence, except when released by me or specifically required by law. I have the right to waive this confidentiality agreement in whole or part at any time.

I also understand that all revealed information about possible felonies or threats of suicide or harm to other human beings will be reported as dictated by the law.

I agree to settle any disagreements I have with Nancy Estelle and if this is not possible, then I agree to turn our concerns over to The Natural Therapies Conflict Resolution Services to mediate an agreement acceptable to both myself and Nancy Estelle.

I acknowledge that I have read and understand this form. I agree to allow Nancy Estelle to help me learn to heal myself using the natural healing techniques and modalities herein listed.

Name of Client _____
Address _____
State/Province _____ Postal Code _____
Signature _____ Date _____
Name if other than client _____
Relationship to client _____

Perfect Balance Natural Health

Informed Consent Christine Armfield

I understand Christine Armfield is Certified Natural Health Practitioner and is allowed to help me improve my own physical, mental, emotional, and spiritual sickness that is manifesting in my life defined by the scope of practice of her registration. I also understand that Christine Armfield will not diagnose, treat or cure those issues, diseases, disorders or conditions.

I further understand that Christine Armfield is a Practitioner who uses biofeedback to help me improve my peak performance in my work, hobbies and other facets of my life.

I understand that I am responsible for my own health, healing and wellbeing. I understand natural healing is not a substitute for additional medical care and I intend to utilize the care of my primary healthcare provider as I deem necessary.

I understand all healing may cause me some minor discomfort and some adverse side effects may occur through no fault of myself or Christine Armfield. I also understand some interventions are contraindicated by the manufacturer and I will be fully advised of these contraindications. I further understand these services may have no effect on me.

I will keep Christine Armfield fully advised about my concerns so the intervention may be terminated if necessary or revised to minimize any harm to me.

I understand that my health and healing is my responsibility; and I choose to use the natural healing services of Christine Armfield to help me heal and improve my health.

I understand Christine Armfield will keep all information she learns about me completely confidential unless I release her in writing or as required by law.

I understand my identity and any information about me, whether I share it with Christine Armfield or she discovers it on her own, will be held in the strictest confidence, except when released by me or specifically required by law. I have the right to waive this confidentiality agreement in whole or part at any time.

I also understand that all revealed information about possible felonies or threats of suicide or harm to other human beings will be reported as dictated by the law.

I agree to settle any disagreements I have with Christine Armfield and if this is not possible, then I agree to turn our concerns over to The Natural Therapies Conflict Resolution Services to mediate an agreement acceptable to both myself and Christine Armfield.

I acknowledge that I have read and understand this form. I agree to allow Christine Armfield to help me learn to heal myself using the natural healing techniques and modalities herein listed.

Name of Client _____
Address _____
State/Province _____ Postal Code _____
Signature _____ Date _____
Name if other than client _____
Relationship to client _____

Perfect Balance Natural Health

Informed Consent Candace Atkinson

I understand Candace Atkinson is Certified Natural Health Practitioner and is allowed to help me improve my own physical, mental, emotional and spiritual sickness that is manifesting in my life defined by the scope of practice of her registration. I also understand that Candace Atkinson will not diagnose, treat or cure those issues, diseases, disorders or conditions.

I further understand that Candace Atkinson is a Practitioner who uses biofeedback to help me improve my peak performance in my work, hobbies and other facets of my life.

I understand that I am responsible for my own health, healing and wellbeing. I understand natural healing is not a substitute for additional medical care and I intend to utilize the care of my primary healthcare provider as I deem necessary.

I understand all healing may cause me some minor discomfort and some adverse side effects may occur through no fault of myself or Candace Atkinson. I also understand some interventions are contraindicated by the manufacturer and I will be fully advised of these contraindications. I further understand these services may have no effect on me.

I will keep Candace Atkinson fully advised about my concerns so the intervention may be terminated if necessary or revised to minimize any harm to me.

I understand that my health and healing is my responsibility; and I choose to use the natural healing services of Candace Atkinson to help me heal and improve my health.

I understand Candace Atkinson will keep all information she learns about me completely confidential unless I release her in writing or as required by law.

I understand my identity and any information about me, whether I share it with Candace Atkinson or she discovers it on her own, will be held in the strictest confidence, except when released by me or specifically required by law. I have the right to waive this confidentiality agreement in whole or part at any time.

I also understand that all revealed information about possible felonies or threats of suicide or harm to other human beings will be reported as dictated by the law.

I agree to settle any disagreements I have with Candace Atkinson and if this is not possible, then I agree to turn our concerns over to The Natural Therapies Conflict Resolution Services to mediate an agreement acceptable to both myself and Candace Atkinson.

I acknowledge that I have read and understand this form. I agree to allow Candace Atkinson to help me learn to heal myself using the natural healing techniques and modalities herein listed.

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Address _____
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Relationship to client _____

Perfect Balance Natural Health

Informed Consent Olivia Massey

I understand Olivia Massey is a Certified Natural Health Practitioner and is allowed to help me improve my own physical, mental, emotional and spiritual sickness that is manifesting in my life defined by the scope of practice of her registration. I also understand that Olivia Massey will not diagnose, treat or cure those issues, diseases, disorders or conditions.

I further understand that Olivia Massey is a Practitioner who uses biofeedback to help me improve my peak performance in my work, hobbies and other facets of my life.

I understand that I am responsible for my own health, healing and wellbeing. I understand natural healing is not a substitute for additional medical care and I intend to utilize the care of my primary healthcare provider as I deem necessary.

I understand all healing may cause me some minor discomfort and some adverse side effects may occur through no fault of myself or Olivia Massey. I also understand some interventions are contraindicated by the manufacturer and I will be fully advised of these contraindications. I further understand these services may have no effect on me.

I will keep Olivia Massey fully advised about my concerns so the intervention may be terminated if necessary or revised to minimize any harm to me.

I understand that my health and healing is my responsibility; and I choose to use the natural healing services of Olivia Massey to help me heal and improve my health.

I understand Olivia Massey will keep all information she learns about me completely confidential unless I release her in writing or as required by law.

I understand my identity and any information about me, whether I share it with Olivia Massey or she discovers it on her own, will be held in the strictest confidence, except when released by me or specifically required by law. I have the right to waive this confidentiality agreement in whole or part at any time.

I also understand that all revealed information about possible felonies or threats of suicide or harm to other human beings will be reported as dictated by the law.

I agree to settle any disagreements I have with Olivia Massey and if this is not possible, then I agree to turn our concerns over to The Natural Therapies Conflict Resolution Services to mediate an agreement acceptable to both myself and Olivia Massey.

I acknowledge that I have read and understand this form. I agree to allow Olivia Massey to help me learn to heal myself using the natural healing techniques and modalities herein listed.

Name of Client _____
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Signature _____ Date _____
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Relationship to client _____

Perfect Balance Natural Health

Informed Consent Tiffany L. Lewis

I understand Tiffany L. Lewis is Certified Natural Health Practitioner and is allowed to help me improve my own physical, mental, emotional and spiritual sickness that is manifesting in my life defined by the scope of practice of her registration. I also understand that Tiffany L. Lewis will not diagnose, treat or cure those issues, diseases, disorders or conditions.

I further understand that Tiffany L. Lewis is a Practitioner who uses biofeedback to help me improve my peak performance in my work, hobbies and other facets of my life.

I understand that I am responsible for my own health, healing, and wellbeing. I understand natural healing is not a substitute for additional medical care and I intend to utilize the care of my primary healthcare provider as I deem necessary.

I understand all healing may cause me some minor discomfort and some adverse side effects may occur through no fault of myself or Tiffany L. Lewis. I also understand some interventions are contraindicated by the manufacturer and I will be fully advised of these contraindications. I further understand these services may have no effect on me.

I will keep Tiffany L. Lewis fully advised about my concerns so the intervention may be terminated if necessary or revised to minimize any harm to me.

I understand that my health and healing is my responsibility; and I choose to use the natural healing services of Tiffany L. Lewis to help me heal and improve my health.

I understand Tiffany L. Lewis will keep all information she learns about me completely confidential unless I release her in writing or as required by law.

I understand my identity and any information about me, whether I share it with Tiffany or she discovers it on her own, will be held in the strictest confidence, except when released by me or specifically required by law. I have the right to waive this confidentiality agreement in whole or part at any time.

I also understand that all revealed information about possible felonies or threats of suicide or harm to other human beings will be reported as dictated by the law.

I agree to settle any disagreements I have with Tiffany L. Lewis and if this is not possible, then I agree to turn our concerns over to The Natural Therapies Conflict Resolution Services to mediate an agreement acceptable to both myself and Tiffany L. Lewis.

I acknowledge that I have read and understand this form. I agree to allow Tiffany L. Lewis to help me learn to heal myself using the natural healing techniques and modalities herein listed.

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Cancellation Policy

When you schedule an appointment with us, we set aside that time for you. We understand that life can be unpredictable, and things happen unexpectedly from time to time. However, if you cannot make it to your scheduled appointment on time, please give us at least 24 hours notice, so that we may make the time available to other clients. We reserve the right to charge you in full for appointments missed without 24 hours notice.

We make every effort to keep on schedule. Please, therefore, be on time for appointments, so that you will receive the full benefit of your visit. Depending upon the length of your scheduled appointment, if you are more than 15 minutes late, we will have to reschedule you and you will be charged for that appointment.

Product Return Policy

Unopened products returned within 30 days of purchase:
Refund or credit toward future services or products.

Unopened products returned after 30 days from date of purchase:
Credit toward future services or products only.

Products will not be accepted for return if opened.

We appreciate your choosing Perfect Balance Natural Health for your health and wellness needs and thank you for your cooperation.

By signing below, I acknowledge that I have read this page and that a copy of it has been made available to me.

_____

Client or Guardian Signature Date

Name: If minor, name of Parents
Address: City: State: Zip:
Home Telephone: Work Telephone: Cell Phone: E-mail: It is acceptable to receive calls about your appointments, or health care information of other than your telephone and e-mails listed above: Yes ____ No ____
Date of Birth: Age: Sex: Marital Status: Married Single Divorced Widowed Name of Spouse: Number of Children: Boys: Ages: Girls: Age:
Employer: Address: City: State: Zip:
In case of emergency please contact: Name: Relationship: Telephone: Address: City: State: Zip:

Who referred you to Perfect Balance?
Chief Complaints
Duration of present condition? What do you believe caused this condition? When were you last seen by a physician? What purpose did you see the physician? Your Primary Care Physician's Name Address: City: State: Zip: Telephone: Diagnosis by your Physician?

The following questions are very helpful for us to know as we help you regain your health. However, this is a voluntary questionnaire.

Medications you are presently taking:	Reason and frequency
1.	
2.	
3.	
4.	
5.	

Supplements you are presently taking.	Reason and frequency
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

Do you use any of the following?	How much and how often:
Coffee	
Tea	
Alcohol	
Chocolate	
Tobacco	
Laxatives	
Sugar	
Artificial Sweeteners	

List any foods that you crave:
List any known allergies to foods or drugs:

Do you have any special diet restrictions?

Do you consider yourself: Overweight Average Underweight
Have you had a weight change over the past year? Is so, how much
How often do you exercise?
Describe your hobbies and interests:

Please Circle the items below that apply to you now or in the past:

Heart Disease	Ankylosing Spondylitis	Eczema
High Blood Pressure	Rheumatoid Arthritis	Alcoholism
Pacemaker	Multiple Sclerosis	Drug Abuse
Defibrillator	Muscular Dystrophy	Scarlet/Rheumatic Fever
Seizures	Mental Illness	HIV/AIDS
Fainting	Auto Immune Disorder	Hepatitis
Cancer	Asthma	Mono/Epstein Barr
Diabetes	Allergies	Abnormal X-ray
Osteoarthritis	Psoriasis	Pregnant/Nursing a Baby

Have you had any accidents, injuries, hospitalizations, surgeries or major illnesses in the past?
If so, describe:

Is your Mother still alive? Yes No
If not, how old was she when she died?
What was the cause of her death?

Is your Father still alive? Yes No
If not, how old was he when he died?
What was the cause of his death?

Is there a history in your family of any of these diseases?			
	Mother	Father	Siblings
Allergies			
Arthritis			
Asthma			
Cancer			
Diabetes			
Heart Disease			
Kidney Disease			
Liver Disease			
Lung Disease			
Mental Illness			
Substance Abuse			
Stomach Disorders			
Other			

Please list the top health areas you want to see improved:

Women only:
Do you have menstrual difficulties? Describe: Date of your last menstrual period? Are you or might you be pregnant? How many times have you been pregnant? Have you had a miscarriage in the past? If so, how many? Have you had difficulty getting pregnant?

Name (Please Print)

Signature (Parent or Guardian if minor) Date