The Natural Path, Ltd.

New Client Information Form

*Please print clearly Page 1 of 9*

General Information

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt.#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_ ZIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like to receive an email copy of our monthly newsletter? Yes [ ] No [ ]

Shipping Address (if different from above) Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt.#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_ ZIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_ Work/Cell Phone (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_

Contact preference: Text [ ] Call [ ]

Referred By \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_ Sex: M/F Height \_\_\_\_\_Weight \_\_\_\_\_

Marital Status: S M D W Name of Spouse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of children (if any): \_\_\_\_\_\_\_\_\_

Overall Health (circle one): Excellent / Good / Fair / Poor / Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health of Spouse (if applicable): Excellent / Good / Fair / Poor / Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies to Medication (list medication & type of reaction): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies to Food (list food & type of reaction):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chief complaint (reason you are here): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Detailed Information

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current medications/drugs being taken (use separate sheet if needed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nutritional supplements being taken (use separate sheet if needed):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under the care of a physician or other health care professional?

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] N/A

Do you smoke, drink coffee or alcohol? (If yes, indicate how much)

Cigarettes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Coffee \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alcohol \_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any major illnesses (w/ approx. dates): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any surgery or operations (w/ approx. dates): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past accidents or injuries (w/ approx. dates). Include any head injuries – concussions, unconsciousness, whiplash, etc.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any scars (including child birth): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any family history or serious illnesses (circle): Cancer/Diabetes/Heart/Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you Pregnant? [ ] Yes [ ] No Are you Breastfeeding? [ ] Yes [ ] No

Are you menstruating? [ ] Yes [ ] No Are you menopausal? [ ] Yes [ ] No

Do you have cancer? [ ] Yes [ ] No Are you in remission? [ ] Yes [ ] No

Do you have epilepsy? [ ] Yes [ ] No Are you photosensitive? [ ] Yes [ ] No

Do you have liver problems? [ ] Yes [ ] No (skip)

 Please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you under the care of a physician? [ ] Yes [ ] No

 Are you taking medication? [ ] Yes [ ] No

If so, please list:­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have diabetes? [ ] Yes [ ] No (skip)

 Are you under the care of a physician? [ ] Yes [ ] No

 Which type? [ ] Type I [ ] Type II [ ] Insulin required (diabetes pills followed by insulin)

 Is your blood sugar monitored? [ ] Yes [ ] No

 By whom? [ ] Myself [ ] Physician [ ] Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Are you taking any medication? If so, please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a pacemaker? [ ] Yes [ ] No

Have you had a cardiovascular event? [ ] Yes [ ] No (skip)

 Please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 How long ago? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Are you under the care of a physician? [ ] Yes [ ] No

 Are you taking medication? (If so, please list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have hypertension (high blood pressure)? [ ] Yes [ ] No (skip)

 Do you have your blood pressure checked? [ ] Yes [ ] No

 Are you under the care of a physician? [ ] Yes [ ] No

 Are you taking medication? (If so, please list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have:

[ ] Irritable colon [ ] Colitis [ ] Diarrhea [ ] Diverticulitis [ ] Crohn’s Disease [ ] Constipation

If so, are you under the care of a physician [ ] Yes [ ] No

Are you taking medication (If so, please list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have: [ ] Acid Reflux [ ] Gastric Ulcer [ ] Heartburn

If so, are you under the care of a physician [ ] Yes [ ] No

Are you taking medication (If so, please list)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have thyroid problems? [ ] Yes (please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] No (skip)

If so, are you under the care of a physician [ ] Yes [ ] No

Are you taking medication (If so, please list)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**SHAPE Program**

**Informed Consent & Acceptance of Responsibility**

**Patient/Client Informed Consent:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand that the SHAPE Program is a lifestyle modification and health restoration program designed to help me improve my overall health. This program is not intended to replace the guidance of my primary healthcare experts. While this program is not used to diagnose, treat, cure or prevent any disease, I understand any medications I am currently taking may need dose adjustments. I agree to notify my prescribing physician that I am working with The Natural Path, Ltd. and will be closely monitored while incorporating this program for embracing a healthier lifestyle. I understand an anti-inflammatory nutrition protocol will be recommended based on my unique health history, urinalysis and symptoms.

**SHAPE Practitioner/Office/Clinic Statement of Intent:**

The Natural Path Ltd.’s intent and responsibility is to determine if the SHAPE Program would be beneficial for assisting your body in its innate healing process. Our first appointment with you will be multi-faceted. We agree to do the following:

* Take full health history and assess your unique needs.
* Discuss your health goals.
* Perform a baseline urinalysis.
* Make specific recommendations as necessary (nutrition, supplements, diagnostics).
* Determine a follow-up schedule.

**Patient/Client Acceptance of Responsibility:**

I have been informed and understand that nutritional and lifestyle recommendations may involve certain risks. These may include, but are not limited to, detoxification symptoms, such as: initially feeling worse due to the release of stored toxins, digestive symptoms, fatigue, headaches, muscle or joint pain, allergic reactions or any unpredictable reaction with my prescribed medications that has not been found in research literature. In addition, I agree to do the following:

* Submit full health history.
* Discuss my health goals.
* Have consistent urinalyses and follow-up visits as recommended by my SHAPE practitioner.
* Read the Program Guidebook.
* Review the information provided on the SHAPE ReClaimed website.
* Be aware that I can join the “OFFICIAL SHAPE ReClaimed Support Group” on Facebook and will not substitute recommendations from Facebook for my specific health needs.

I have read (or have had read to me) the above information. I have had the opportunity to ask questions about its contents and by signing below, I agree to these conditions for the duration of my SHAPE Program journey.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name (Print) Signature**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Practitioner Name (Print) Date Signed**

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The Natural Path, Ltd.

Authorizations

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**Authorization for the use of Complementary and Alternative Care**

I have been advised that The Natural Path, Ltd. (2212 S. College, Ave, Ft. Collins, CO 80525, 970-829-1110) offers complementary and alternative health care services pursuant to "Colorado Natural Health Consumer Protection Act" SB13-215. As such, they are not licensed, certified, or registered by the state as health care professionals. The Natural Path, Ltd. is not affiliated with any Naturopathic Doctors nor practices any form of Naturopathic Medicine.

 I may be provided any of the following services: Neuro Emotional Technique (NET®), Nutritional Kinesiology (muscle testing), Biofeedback, Body Work Therapies, and Diet and Lifestyle Recommendations. Carl Malone’s credentials to provide these services include the following:

* American Naturopathic Medical Certification Board – Board Certified Doctor of Natural Medicine (#06724)
* Doctor of Natural Medicine (IBEM 2013)
* Doctor of BioEnergetic Medicine (IBEM 2013)
* Doctor of Sacred Medicine (IBEM 2013)
* Certified Biofeedback Practitioner (IBEM 2012)
* Psychotherapist (#NLC.0108586)
* Colorado Registered Massage Therapist (#MT0009541)
* Craniosacral Therapy - (Upledger Institute 2004)
* Brimhall Certified Practitioner (2011)
* Nutrition Response Testing (2014)
* Neuro Emotional Technique (2016)
* Muscle Response Analysis (2016)
* Contact Reflex Analysis (2018)
* SHAPE ReClaimed Certified Practitioner (2021)
* Founder of LaserNMT training for Practitioners

In addition to formal credentials, Carl Malone has attended numerous seminars and hours of training in health, nutrition and body work, with a particular focus on low-level laser therapy.

The information and services provided to me are not intended to be a substitute for obtaining professional medical advice, diagnosis, or treatment. The Natural Path, Ltd. is not a licensed medical entity, is not affiliated withinsurance entities, and does not practice medicine, or render medical advice. I am encouraged to always discuss recommendations made by any complementary and alternative health care provider with my primary care physician.

Client (printed name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

The Natural Path, Ltd.

Authorizations

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**Authorization for the use of Neuro Emotional Technique (NET®)**

The information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client’s consent.

Client (printed name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

**Authorization for the use of Nutritional Kinesiology**

 I specifically authorize the natural health practitioners at The Natural Path, Ltd. to perform a non-invasive health analysis using Nutritional Kinesiology. The purpose of this exam is to develop a natural health improvement program for me, which may include dietary modifications, nutritional supplementation, natural body and system cleanses, as well as ongoing education. The purpose of which is to improve my overall health, and not for the purpose of treatment or “cure” of any known or unknown disease.

 I understand that Nutritional Kinesiology is a safe, non-invasive, natural approach for analyzing the body's physical and nutritional needs as well as identify possible deficiencies or imbalances in areas that could cause or contribute to my various health concerns.

 I understand that Nutritional Kinesiology is not a method for diagnosing or treating any known or unknown disease including conditions such as cancer, diabetes, heart disease, infections or other medical conditions and that these are not being tested for or treated.

 No promise or guarantee has been made regarding the results of Nutritional Kinesiology or any natural health, nutritional or dietary program recommended. I understand that Nutritional Kinesiology is a means by which the body's natural reflexes can be used to aid in determining possible nutritional imbalances, so that a safe natural program can be developed for the purpose of bringing about a more optimal state of health.

Client (printed name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

The Natural Path, Ltd.

Authorization

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**Authorization for the use of Body Therapy and Cold Laser Therapy**

I, the undersigned client, hereby authorize The Natural Path, Ltd. appointed staff to administer such therapy as is necessary. I hereby certify that I understand the advantages and possible complications. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Client (printed name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

**Regarding Your Pharmaceutical Medications:**

At The Natural Path, Ltd., we DO NOT prescribe or “un-prescribe” any pharmaceutical medications. All dosing of your prescription medications must be done through the doctor who prescribed them for you.

Client (printed name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

**Regarding Insurance Claims:**

This office is NOT an approved direct provider to insurance companies. As such, we do not provide a Medical Necessity letter to any insurance companies for reimbursement of services or products.

We will provide you with a copy of your file, if needed for reimbursement, for a $5.00 documentation preparation fee. A copy of your receipt in payment for product and services will be provided to you following each of your visits.

Client (printed name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

All above authorizations need to be signed and dated, indicating that you have read and understand each. If a minor, the signature of a parent or guardian is required. These signed authorizations apply to subsequent visits and consultations provided either in person or remotely.

The Natural Path, Ltd.

Office Policies

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**Payments**

* Payment is due at time of service. We do not bill insurance.
* We accept cash, check or debit/credit. We prefer cash or check and may have to charge a credit card fee for large purchases.

Initial \_\_\_\_\_\_\_\_\_

**Refunds**

* Refunds are not provided for services already rendered.
* Products may be returned for refund if unopened and undamaged within 30 days of purchase. Credit card fees are not refunded.

Initial \_\_\_\_\_\_\_\_\_

**Appointments**

* Appointments may be cancelled or rescheduled with at least 24 hour notice.
* **More than 2 late cancellations** (less than 24 hour notice) are subject to all future appointments being prepaid or loss of a session if already prepaid.
* If more than 10 minutes late, the appointment may need to be rescheduled. Please understand that your appointment may be shortened if you are running behind.
* **‘No Show/No Call’ appointments** are subject to charge or loss of a session if session has been prepaid, as well as future appointments being prepaid.

Initial \_\_\_\_\_\_\_\_\_

We do our best to accommodate everyone’s scheduling needs. However, if you are unsure if you can commit to an appointment time, please consider calling on short-notice to see if there is availability rather than scheduling in advance. Cancellations, late arrivals and ‘No Show/No Calls’ may result in someone else not receiving the care they need at that time.

Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Member Name Date Address

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City / State / Zip Email Member Signature

 Enrolled Into Membership By: \_\_\_\_\_\_MALONE\_\_\_\_\_\_\_ PWA Provider #\_\_\_\_\_\_2450\_\_\_\_\_\_\_\_\_\_\_\_

Professional Wellness Alliance Member Agreement 2020