

Holistic Health Patient Agreement

At Holistic Health we strive to promote the utmost integrity and respect with patient relations. In order to ensure that each patient receives quality care we ask that you read, understand and agree to the following:

I agree to make all appointments as scheduled in order to ensure maximum progress in my case. I understand that if I do not show up for my appointment, cancel or reschedule less than 24 hours before my scheduled appointment, I will be charged \$35.00.

Initial _____

I agree to follow my protocol recommended to me by my practitioner to the best of my ability. I understand it may take several weeks before any noticeable improvement.

Initial _____

I understand that my practitioner and the staff at Holistic Health have the right to discontinue my care at any time if they determine appropriate. Conditions that may terminate care may include, but are not limited to the following:

- Purchasing of homeopathic protocol from other providers/vendors. If products are purchased elsewhere, we cannot ensure quality, handling or correct storage. If you do decide to purchase through another provider/vendor, we will ask that you switch your care to the provider you are purchasing through. Because of this we try to keep our testing fees and product pricing low.
- Inappropriate behavior or language towards the practitioner or staff
- Multiple late cancellations and no shows to appointments

Initial _____

I acknowledge that Holistic Health does not bill out to insurance. The consultations and treatment modalities administered at Holistic Health are not recognized or covered by insurance companies. I agree to pay out of pocket for each service offered at Holistic Health with the understanding that I most likely will not be reimbursed by my private insurance carrier. If I am on Medicare/Medicaid I acknowledge that I cannot submit any claims for services offered at Holistic Health.

Initial _____

I understand that if I'm working with other medical providers, Holistic Health cannot claim to treat or diagnose from electrodermal screening and the protocols to treat the diagnosis are not recognized in mainstream medicine.

Initial _____

Signature (Parent/Legal Guardian)

Patient(s) names

Printed Name

Date