Client Information

Name: ____Today's Date: ___________

Address: ___________________________________City:_____________________________

State: _________________Zip:_________Email:____________________________________

Home/Business Phone: ______________________Cell: ___________________________

Occupation: _________________________________ Age: _____ Birth date: _______________

How did you hear about us? ____

<u>Notice of Understanding and Agreement</u>

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.

<u>Cancellation/Reschedule Policy:</u>

At QHC we value and respect your time. Our promise to you is that we will not keep you waiting and that your appointment will begin on time. Unlike many traditional practices, we do NOT double book our appointments; the time we have reserved for your health care is dedicated solely to you.

As such, we require a minimum notice of 24 hours be given for any appointment change or cancellation. Clients who arrive late by 20 minutes or more will have to reschedule their appointment. A $50 rescheduling/cancellation fee will be charged for all changes and cancellations made with less than 24 hours of notice.

<u>Missed Appointments:</u> ***Patients who do not give any notification prior to a missed appointment will be charged a fee of $100.***

Please initial to acknowledge that you understand and agree to these scheduling policies _______.

Consent for a Minor or Dependent (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 _____________________

5904 Grizzard Court Peachtree Corners, GA 30092 Phone 770.446.1140