Nourishing Journey

Date: _____

Intake Form

Demographics

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Date of Birth: _____ Age: _____ Sex: M / F

Primary Care Physician

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date of Last Checkup: _____

In Case of Emergency

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

How Did You Hear About Us?

- ☐ Friend: _____
- ☐ Practitioner: _____
- ☐ Website: _____
- ☐ Other: _____

Nourishing Journey

Date: _____

Acknowledgement and Consent for Services

1. I understand and acknowledge that all non-medical practitioner recommendations, suggestions, and references to lifestyle, foods, homeopathy or nutritional supplements do NOT involve diagnosing or prescribing for the treatment of any disease or health condition. These suggestions are used to help balance the body so that the body is better able to heal, and they are meant to be used in conjunction with proper medical care.

2. I understand that any "intuitive information" provided is for informational support only and is not to be considered a diagnosis. I understand that body work and energy work complement medical or psychological care I may be receiving, but do not replace it.

3. **DISCLOSURE**
   I understand that it is never recommended that I discontinue any medical regimen or advice given by my medical doctor. I understand that I need to make my licensed physician aware of all healing modalities and natural supplements I am incorporating into my wellness plan.

4. I understand that, depending on the service and on the practitioner, there may be hands-on techniques, hands-off techniques or combinations of same, always with integrity and with my comfort as the utmost concern. Therefore, I agree to let the practitioner know my comfort level immediately during the session.

5. **WAIVER OF RESPONSIBILITY**
   I am 18 years of age or older and have read and understand the above and acknowledge that no guarantees or warranties have been made to me as to the success, value, or benefit of alternative holistic wellness procedures. I acknowledge that long-standing imbalances sometimes require multiple sessions in order to facilitate the adjustments needed by the body to heal itself.

6. Everyone's time is valuable. If I need to cancel or reschedule an appointment, I understand that Nourishing Journey requires 24- hour notice and that Nourishing Journey reserves the right to charge me for a missed appointment. Late cancels or no shows may be subject to charges of:

   a. Half of the full price fee for each service scheduled.
   b. These rates are subject to change at any time and will not exceed the full cost of an appointment's price.

7. I understand that if I am late to an appointment, the appointment may end at the scheduled time and I am responsible for the full price of the appointment. Practitioners will do their best to accommodate late arrivals while respecting the schedules of other clients.

My signature below signifies that I have read and understand what is written above.

Client/Guardian Signature: _____

Client/Guardian (printed): _____

Client Name if Minor: _____

Notice of Privacy Practices

We are committed to respecting your privacy. The information you provide to us is kept confidential and is only disclosed if you have requested it in writing or if it is necessary under other circumstances. This notice lists some of the circumstances when we may use or disclose your health information.

Other Professionals: We may use and disclose your health information when coordinating with other health care professionals who are assisting or treating you. Your consent must be given in advance before any information is shared with professionals outside of Nourishing Journey.

Emergencies: We may use or disclose your health information to notify or assist in the notification of a family member or anyone responsible for your care in case of an emergency. If possible, we will provide you with an opportunity for consent, however if you are incapacitated, we will use our professional judgment to disclose only the information that is directly relevant to your care.

Others Involved In Your Care: We may use or disclose your health information to other family members involved in your care. Your consent must be given in advance before any information is shared.

Required By Law: We may use or disclose your health information when we are required to do so by law. This may be in response to a court or administrative order, subpoena, discovery request, or any other lawful process.

Abuse or Neglect: We may use or disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or the possible victim of other crimes. This information will be disclosed only as necessary.

You have the right to look at or get copies of your information at any time. If you request copies you will be charged $1.00 for each page, and postage if you want the copies mailed to you.

By signing below, I acknowledge that I have received and reviewed the information pertaining to the Notice of Privacy Practices.

Client/Guardian Signature: _____ Date: _____

Client/Guardian (printed): _____

Client Name if Minor: _____