CLIENT INFORMATION SHEET

2256 Alben Dr.
Luzerne, MI 48636
361-317-2020
NaturalWorks.US

CLIENT INFORMATION:

NAME: _____

ADDRESS: _____

_____

PHONE#: _____

E-MAIL: _____

PERSONAL INFORMATION: ☐ Human ☐ Animal/pet (Species & Breed:) _____

AGE: _____ DATE OF BIRTH: _____/_____/_____ BIOLOGICAL SEX: M / F REFERRED BY: _____

OCCUPATION: _____ FULL TIME / PART TIME / NOT WORKING / RETIRED

DIRECTIONS:

1) Visit NaturalWorks.US to schedule a Biofeedback appointment for $235.
2) Exactly 3 days prior to your selected appointment date, place TWO Q-Tips saturated with saliva in a zip lock bag and tightly seal it.
3) Exactly 3 days prior to your appointment date, place at least a tablespoon of "scrunched" hair in a separate zip lock bag and tightly seal it.
4) Place both zip lock bags into a third zip lock bag and tightly seal it.
5) Print and complete this information sheet.
6) Mail sealed bags along with this completed information sheet to the above address via 2nd Day Delivery (FED-EX or UPS only) EXACTLY 3 days prior to your scheduled appointment.
7) Results of the Biofeedback scanning appointment will be emailed to you.
8) Call 361-317-2020 exactly ONE HOUR after your appointment time to discuss results with the Health Practitioner IF you have checked the corresponding box below.
9) Receive requested nutritionals according to your selected shipping preferences as indicated in the next section below.

DATE & TIME OF APPOINTMENT:

____/____/20____ ____:____AM/PM

PAYMENT INFORMATION: (checks not accepted)

CREDIT CARD #: _____ 3 DIGIT CVV #: _____

EXPIRATION DATE: ____/____/20____ CIRCLE ONE: VISA MASTERCARD DISCOVER AMEX

CHOOSE ONE:

☐ I will ☐ I will not, call Natural Works office exactly ONE HOUR after my appointment time to discuss the results with the Health Practitioner at 361-317-2020.

CHOOSE ONE:

☐ Have all nutritional aides from the program shipped directly to my address listed above.

☐ Have the office call me to order specific nutritional products.

I authorize Natural Works to charge my credit card as designated above.

CURRENT CONCERNS & ADDITIONAL INFORMATION

_____

_____

_____

_____

HEALTH INFORMATION
(New Clients Only)

HEALTH HISTORY:

All PRIOR DIAGNOSES: _____

HOSPITALIZATIONS: _____

MEDICATIONS: _____

SUPPLIMENTS: _____

HEALTH HABITS: Please Circle	NEVER	FEW TIMES A MONTH	1-2 TIMES A WEEK	3-7 TIMES A WEEK	DAILY
EXERCISE:	X	X	X	X	X
ALCOHOL:	X	X	X	X	X
TOBACCO:	X	X	X	X	X
COFFEE, TEA, SODA	X	X	X	X	X

FREQUENCY OF BOWEL MOVEMENTS:	1 EVERY 2-3 DAYS	1 EVERY DAY	2-3 A DAY
FREQUENCY OF NIGHT URINATION:	2 OR MORE	1-2	0

WOMEN:
PREGNANT: Y/N NURSING: Y/N PRESCRIPTION BIRTH CONTROL: Y/N

DISCLOSURE STATEMENT AND AUTHORIZATION:

Natural Works provides a consulting service to help support the whole person reestablish balance through removing obstacles to health and encourage the body's natural healing process. By signing below I understand that the computerized Biofeedback scan and Natural Works and/or any employees or associates do not function as a physician, diagnose or treat disease, nor do their services replace the services of a licensed physician. If I suspect that I or my dependent(s) need further medical intervention, I should consult a licensed physician. I give my permission for the testing technician to evaluate me on the Vital System and that by doing so the testing technician does not become my primary care physician. I agree my health and life choices are my own, I have not been coerced or unduly pressured to participate in this or any future service, product, etc. I acknowledge and agree I am responsible for my own body and hold harmless Natural Works, its affiliates, employees, assistants, etc. from any and all liabilities, outcomes, symptoms (psychosomatic or otherwise) improvements, etc. It is of my own volition that I do or do not participate.

Medicare patients are being advised that services and products received in this office do not qualify for reimbursement and are considered non-covered by Medicare and insurance agencies. Due to Law #PL104-191 Kennedy-Kassebaum Natural Works will not file Medicare claims or forms. A cash receipt can be given to you, however it is not to be filed with insurance carriers or Medicare for reimbursement or toward detectable satisfaction.

To the best of my knowledge the above questions have been accurately answered. I understand that providing incorrect or inadequate information can be dangerous to my health. I agree I am responsible for full payment of all products and services rendered on my behalf or my dependents as laid out in my selected preferences above. I understand Natural Works may take collection procedures if the entire balance is not paid in full at time of service and that I, the client am fully responsible for any and all fees incurred due to collection activity, including attorney fees, court costs, etc. By signing below I certify I am sound of mind and that I have read the disclosure and authorization agreement and understand the limits of these services, and assume full responsibility and liability for this decision and all outcomes, none withstanding. Signing this form represents my complete comprehension of aforementioned statements.

PRINTED NAME OF CLIENT:
(or parent/legal guardian if minor)

_____

SIGNATURE OF CLIENT:
(or parent/legal guardian if minor)

_____

DATE:
_____/_____/20_____