RENO INTEGRATIVE MEDICAL CENTER

6110 Plumas St. Suite B

Reno, NV 89519

(775.) 829-1009

STATEMENT OF INTENT

By my signature below I acknowledge the following:

* I wish to consult Kathy Goldsworthy, solely for reasons concerning my own personal health.
* I am not associated with and do not represent any enforcement, regulatory, or investigative agency of either the municipal, state, or federal government, or any other investigative agency which monitors any aspect of health care or the practice of medicine.
* I am not consulting the above health care professionals in order to report to or otherwise provide any information to any enforcement, regulatory, or federal government, or any other investigative agency.

By my signature below I certify that I have read the above statements and that they are true.

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

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_