



832 2nd Ave NW
Hickory, NC 28601
Phone: 828-328-4673

Websites:
www.PowerToThrive.com
www.PowerToThriveRadio.com

GPL Intake and Informed Consent
(Complete 1 packet per patient)

Patient's Name: _____ DOB: _____

Parent's Name (if patient is a minor): _____

Is the patient 18 years or older? Yes No
If no, do you have custody of this patient and medical decision-making rights? Yes No
(If you have been through a divorce and have legal custody of the patient, please provide a copy of the custody paperwork)

Patient's Address (to send kit): _____

Patient's/Parent's Cell: _____ Email to send results: _____

Please indicate which test(s) you are requesting: _____

Please list below, history and reasons you believe that a Great Plains Test might benefit you/your child.
(Use additional paper if necessary)

Please sign below if you understand the following and consent to participating in consultations with Liza Shaw: Liza Shaw is not a Medical doctor, but rather, an Integrative Health Coach and PANS/PANDAS/Lyme Literate Consultant. While Ms. Shaw possesses a great deal of knowledge and experience working with clients who present with these medical conditions, she does not provide medical diagnoses, nor can she prescribe medications. During consultations, Ms. Shaw may provide suggestions or information to clients, however, this is meant to be educational in nature only, and is NOT intended to replace medical treatment from a licensed physician. Consultations with Ms. Shaw may be conditional based upon patient/parent/guardian securing a medical specialist to treat any active infections/medical conditions and may be terminated if patient/parent/guardian is unwilling to seek medical treatment. Consultations with Ms. Shaw are also NOT therapy, and Ms. Shaw is not acting in the role of therapist when providing these services. Participating in Consultations with Liza Shaw will not guarantee any particular outcome, either expressly or implicitly.

Signature – Patient (or Parent/Guardian)

Signature – additional Parent/Guardian

Print Name

Print Name



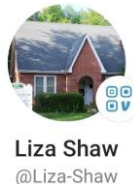
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PAYMENT OPTIONS AND OPTIONAL CREDIT CARD AUTHORIZATION FORM

Patient's Name: _____ DOB: _____

Check this box if you will use Venmo, or Paypal via Facebook Pay. Either of these payment options give you the biggest discount on the cost of the tests (the Mycotox and Organic Acids Test are each \$317. If you have ordered other tests, please contact us to get the test prices and total charges. Our Venmo account is @Liza-Shaw, and the picture on the account is displayed to the right of this sentence. ----->
 If you use Paypal via Facebook Pay, you will have all of the buyer protection of Paypal, but with no fees and with the convenience of paying right from the Facebook Messenger app. If you need assistance getting your Paypal account connected to your Facebook Messenger account, please let us know and we can walk you through the process.



Check this box if you want to use your credit/debit/HSA card, for a one-time purchase. This payment option reduces the discount, making the cost of the Mycotox and Organic Acids test each \$326. instead of \$317. Your card will not be stored or used for any future purchases without your express permission. If you choose this option, you do not need to complete any other part of this form.

If you prefer to have us keep your card on file, please complete all below fields. You may cancel the below authorization at any time by contacting us. This authorization will remain in effect until canceled. By checking the box below, you authorize us to store the card number in our system, to be used for any future purchases you may make through us.

Credit Card Information	
Card Type: <input type="checkbox"/> MasterCard <input type="checkbox"/> VISA <input type="checkbox"/> Discover (we do not accept AMEX)	
Cardholder Name: (As shown on card):	
Card Number:	
Expiration Date (mm/yy):	Security Code:
Cardholder ZIP Code (from credit card billing address):	

Please keep this card on file and use whenever a service or product has been purchased. (Insert full name and sign, below)

I, _____, authorize Liza M. Shaw/Marriage and Family Therapy Services, PLLC to charge the above credit/Debit/HSA card above for agreed upon purchases. I understand that my information will be saved, on file, for future transactions on my account until I request for it to be removed from the system.

 Customer Signature

 Date