



832 2<sup>nd</sup> Ave NW  
Hickory, NC 28601  
Phone: 828-328-4673

**Websites:**  
[www.PowerToThrive.com](http://www.PowerToThrive.com)  
[www.PowerToThriveRadio.com](http://www.PowerToThriveRadio.com)

**Galaxy Labs Test - Intake and Informed Consent**

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 list below, history and reasons you believe that a Galaxy Labs 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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### CREDIT CARD AUTHORIZATION FORM

Name on Credit Card: \_\_\_\_\_ Patient's Name (if different): \_\_\_\_\_

Email: \_\_\_\_\_

- Check this box if you want to make this a one-time purchase. You will receive an email link and your card will not be stored 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 this authorization at any time by contacting us. This authorization will remain in effect until cancelled. You will receive an email link to make your current purchase for the GPL Tests, however, by checking this box, you also authorize us to store the card number in our system, to be used for any future purchases you 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):		
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 name, below)

I, \_\_\_\_\_, authorize Liza M. Shaw/Marriage and Family Therapy Services, PLLC to charge my credit 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