

# **RELEASE OF LIABILITY, INFORMED CONSENT, AND CLIENT AGREEMENT**

## **Unified Naturopathic Wellness and Spiritual Guidance**

**Provider: Dr. Heather Adams Buckley, BCND (non-medical)**

### **Nature of Services (Non-Medical)**

I understand services are educational, wellness-oriented, and non-medical. The provider does not diagnose disease, prescribe medication, perform medical procedures, or replace care from a licensed physician or other state-licensed health professional. I remain responsible for seeking licensed medical care when indicated and for emergencies.

### **Client Responsibilities**

I agree to: (a) share accurate health history; (b) use my own judgment in applying recommendations; (c) seek urgent or routine medical care from licensed professionals as needed; (d) inform the provider of pregnancy, medications, or significant conditions.

### **Risks; No Guarantees**

Wellness and lifestyle modalities can produce varied responses. I assume all ordinary risks inherent in consultations, self-care changes, dietary or supplement choices, and mind-body practices. No outcome is promised.

### **RELEASE AND WAIVER OF LIABILITY (INCLUDING ORDINARY NEGLIGENCE)**

**TO THE FULLEST EXTENT PERMITTED BY TEXAS LAW, I RELEASE AND DISCHARGE THE PROVIDER, THE BUSINESS, OWNERS, EMPLOYEES, CONTRACTORS, AND AFFILIATES (“RELEASED PARTIES”) FROM ALL CLAIMS, DEMANDS, OR CAUSES OF ACTION FOR INJURY, ILLNESS, LOSS, OR DAMAGES ARISING OUT OF OR RELATED TO SERVICES, INCLUDING CLAIMS CAUSED IN WHOLE OR IN PART BY THE ORDINARY NEGLIGENCE OF ANY RELEASED PARTY. THIS RELEASE DOES NOT APPLY TO GROSS NEGLIGENCE, WILLFUL MISCONDUCT, OR VIOLATIONS OF LAW.**

### **Indemnity**

To the extent allowed by law, I agree to indemnify and hold Released Parties harmless from third-party claims arising from my breach of this Agreement or my misuse of recommendations.

### **Informed Consent to Recommendations**

I consent to receive education about lifestyle, nutrition, herbs/supplements, stress-reduction, and other natural approaches. I may accept or decline any suggestion.

### **Financial, Scheduling, and Cancellation**

Fees, refunds, and cancellation terms are posted or stated at booking and incorporated here. A minimum of 24 hours notice is required for cancellations or rescheduling. Appointments canceled

within 24 hours, or missed without notice, incur a \$100 non-refundable fee.

**Privacy**

The practice protects my information consistent with its Privacy Notice. I consent to secure electronic communication and records for scheduling and documentation.

Client Name: \_\_\_\_\_ Phone/Email: \_\_\_\_\_

Address: \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian (if applicable): \_\_\_\_\_ Relationship: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_