

### BIOMAT INTAKE FORM

Please complete the following questions carefully.

#### *How Did You Learn About Our Services?*

Personal Referral \_\_\_ Doctor/Practitioner \_\_\_ Print Ad \_\_\_ Internet \_\_\_ Facebook \_\_\_ Other \_\_\_

Who May We Thank for the Referral?: \_\_\_\_\_

Name: \_\_\_\_\_ M [ ] F [ ] Birth date \_\_\_ / \_\_\_ / \_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Marital Status: S [ ] M [ ] D [ ] W [ ] # children: \_\_\_\_\_

Home # ( ) \_\_\_\_\_ Work # ( ) \_\_\_\_\_ Cell # ( ) \_\_\_\_\_

Email address: \_\_\_\_\_ May we contact you at this address? **Y N**

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**Please note: BioMat Therapy should not be used by infants, young children or the elderly.**

1. Are you now under a doctor's care? \_\_\_\_\_ If so, please explain: \_\_\_\_\_

2. Doctor's name \_\_\_\_\_ Phone: \_\_\_\_\_

3. Select any of the following situations that apply to you (contraindicated for BioMat Therapy):

\_\_\_ Organ transplant recipient \_\_\_ High Fever \_\_\_ Cognitive disability

\_\_\_ Skin problems on your back \_\_\_ Acute Disease \_\_\_ Acute Tumor

\_\_\_ Visually impaired \_\_\_ Heart problem

4. Select any of the following that apply to you (requires approval of physician):

\_\_\_ Immobility \_\_\_ Pacemaker/defibrillator \_\_\_ Adrenal Insufficiency

\_\_\_ Lupus \_\_\_ Addison's Disease \_\_\_ Multiple Sclerosis

\_\_\_ By-pass surgery \_\_\_ Diabetes \_\_\_ High blood pressure \_\_\_ Pregnant

\_\_\_ Recent chemotherapy/radiation \_\_\_ Surgical/silicone breast implants

9. **Pain:** Please list any specific areas/types of pain (ex: joint/muscular/abdominal): \_\_\_\_\_

10. What do you hope to achieve from this BioMat Therapy appointment? \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Annette Barber, BS, CNHP, CCHT**  
**www.gentle-pathways.com**

## FINANCIAL & CANCELLATION POLICY AND RELEASE STATEMENT

**Mini-Session ~ \$35** (approximately 40 mins)      **Full-Session ~ \$55** (approximately 60 mins)

**Series of 3 Mini-Sessions** (pre-paid) ~ **\$90**      **Series of 3 Full-Sessions** (pre-paid) ~ **\$150**

**Missed Appointments** ~ (Mini-Sessions - \$15, Full Sessions - \$30)

**Returned Check Fee** ~ \$25

All payments are due at the time of visit. **Preferred method of payment is cash or checks.** For your convenience we do accept Visa, MC and Discover and American Express. The above prices are subject to change. *There may be times when promotional prices are offered.*

**Cancellation Policy:** If you don't show up for your appointment or if less than 24 hours notice is given to change or cancel an appointment, you will be charged a fee up to \$30 for the missed appointment or you will forfeit a prepaid session. (Special circumstances are considered on a case by case basis).

I acknowledge that Annette Barber, owner and therapist at Gentle Pathways, is not a medical doctor. I understand that Annette Barber may provide nutritional and other health related information to help me attain and maintain my best health. All suggestions are designed to help me move towards my best state of health through personalized recommendations in lifestyle, exercise, health habits and nutrition. I understand that Annette Barber does NOT diagnose, treat or claim to cure any illness or disease.

I am here on this day and any subsequent visit by my choice and solely on my own behalf. I hereby release and discharge Annette Barber, Gentle Pathways from any and all claims which I or my agents ever had, now have or may have relating to or arising out of services provided or recommendations that I have received. I acknowledge that it is my responsibility to consult with my physician or other health care providers relating to any disease or condition that I may have.

I give permission to share my health information with other practitioners and health care professionals who are also providing services for my care. (*Your Initials:* \_\_\_\_\_)

I have read this informed consent and understand it. I am not a minor (under the age of 18). I understand the above Financial & Cancellation Policy and will abide by these charges. I am signing this release voluntarily.

\_\_\_\_\_  
Client Name (Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client Name (Printed)