Mayberry Naturopathy

New Intake Forms

Name: _____ DOB: _____ Age: _____ M/F

Address: _____
_____
_____

Phone: _____ **Email**: _____

Emergency Contact: _____ Phone: _____

How did you hear about us? _____

Top 3 Health Concerns: _____
_____
_____

Vitamins/Supplements currently taking?
_____
_____
_____
_____

Medications currently taking?
_____
_____
_____

Relevant Medical History: (past illnesses, surgeries, etc.)
_____
_____
_____
_____

Allergies: (food or environmental) _____
_____
_____

Immediate Family Health History:

mother_____

father _____

siblings _____

DECLARATION AND CONSENT TO CARE
DISCLOSURE AND RELEASE AND WAIVER OF LIABILITY AGREEMENT
for Mayberry Naturopathy LLC

Traditional Doctors of Naturopathy and Naturopathic Practitioners minimize the risk of harmful side effects, by supporting the body's own capacity to heal and by using the least invasive procedures for evaluation and care protocols whenever possible. It is very important that you inform your doctor of naturopathy or doctor of medicine on this form and hereafter during care of any disease process that you are suffering from, if you are on any prescription medication or over the counter drugs or if you are pregnant, suspect you are pregnant, actively attempting to become pregnant or you are breast-feeding.

I understand that a record will be kept of the health or consulting services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or when law requires it. I understand that my naturopath will answer any questions to the best of his/her ability and will exercise judgment during the course of the procedure which he or she feels at that time is in my best interests, based on the facts then known. I intend this consent form to cover the entire course of care for my present health concern(s) and agree to abide by the custom care plan ascribed by the practitioner for my specific case. This includes patient visits ascribed, natural medicines recommended and scheduling courtesies. I understand that this office does not prescribe or practice pharmaceutical medicine, unless the practitioner seen is licensed to do so. I understand that I am free to bring any previous paperwork, labs, etc. from other providers as a support for my care, as this aligns with our holistic plan in the support of integrated care with all health care providers. I understand that this office will not be responsible should I not disclose any medical information relevant to my care, which could contraindicate protocols issued in this office.

Mayberry Naturopathy, makes no representations, claims, or guarantees regarding the efficacy of their recommendations. The recommendations are based upon a combination of extensive naturopathic psychology, naturopathic health and holistic knowledge and education.

A natural health consultation as provided by Mayberry Naturopathy associates does not constitute a medical or pharmaceutical service or treatment. The title of "Licensed Practitioner"

is used to indicate the achievement of naturopathic and integrative holistic qualifications and does not imply nor require that Mayberry Naturopathy associates hold state licensure to practice medicine. Each associate holds board certifications, licenses, diplomas, degrees, registrations, etc. strict to their specific scope of practice and to establish and maintain credibility in the field. (i.e. RNHP, RN, DC, HHP, ND, PhD, MHD, LPCT, etc.). The practice of Traditional Naturopathy is not considered the practice of medicine and is currently legal in all 50 states, except South Carolina and Tennessee. The practice of Traditional Naturopathy is recognized as a common occupation at the Federal level (U.S. Congress 1928, 1929, 1930 and 30 Federal Court rulings between 1958 and 1978) and as such it is a profession protected under the 14th and 9th Amendments of the U.S. Constitution. Some of our clinicians also carry GEHA licensure, Guardian Ecclesiastical Medical Association, and are protected under law to practice within the scope of ministerial holistic health care. More information on each of our practitioners' credentialing and background is available on the *mayberryclinic.com* website.
Individualized recommendations are offered and applied as an educational and informative consultation. Any action taken as a result of the consultation is done at the sole discretion of the client.Therefore, it is strongly recommended that in addition to any health consultation that you maintain a relationship with one or more physicians qualified to care for bodily or mental health condition(s) as the need fits. Mayberry associates always collaborate, with client permission, with other doctors in regard to client/patient care. By signing this informed consent you agree to forever release Mayberry Naturopathy associates, their officers and employees from any and all actions, claims or demands that you, your heirs, next of kin, spouse and legal representatives now have, or may have in the future related in your participation of a natural health consultation. You agree to be responsible for all legal costs and fees that may result from action(s) on your part or on the part of your representative(s) against us. If a legal case is brought, you agree that we shall be judged by the standards and principles of complementary.alternative, and/or holistic medicine and not the standards and principles of consensus conventional medicine. You have the right to have this consent reviewed by your lawyer. Mayberry Naturopathy practitioners each hold liability insurance coverage for their scope of practice. Your signature verifies that you have not been told to discontinue treatments with any other medical specialists or other health care providers. Your signature is being given prior to rendering any service.advice, and/or recommendations whatsoever. By entering your signature below you are acknowledging that you understand all terms, verbiage and concepts herein. I understand that payment for services rendered is expected on the day of my visit, along with costs of natural medicines and testing- if applicable. For tele-health/virtual and phone appointments, payment must be rendered by office staff at the close of the call. For in-person visits, payment is expected at the close of the visit. Missed appointments require at least 24-hours notice and patients who do not show or reschedule after 3 missed appointments may be discharged from care. This office reserves the right to charge a no-show fee or late cancellation fee for appointments not kept. Patients who do not make an attempt to adhere to the therapy plan given will be discharged from care. By signing, you also acknowledge that our time slotted for each new appointment can be no longer than 40 minutes and follow up visits no longer than 15 minutes. Going over this time allowance will result in an extended visit charge. I understand this consent agreement and understand the contents. I am signing for myself or on behalf of a minor receiving care today.

_____ _____

Patient/Client Date

_____

Legal Guardian (if patient/client is a minor)