

CLIENT INFORMATION AND INFORMED CONSENT FORM FOR NUPATH WELLNESS

Thank you for choosing Jill Diaz as your holistic practitioner. I am committed to your health and wellness.

Name: _____

PLEASE READ THE FOLLOWING INFORMATION AND SIGN BELOW:

I UNDERSTAND THAT JILL DIAZ ARE NOT MEDICAL DOCTORS, AND DO NOT DIAGNOSE ILLNESS, DISEASE, OR ANY PHYSICAL OR MENTAL DISORDER. I UNDERSTAND THAT ALTERNATIVE HOLISTIC THERAPIES ARE NOT SUBSTITUTES FOR MEDICAL TREATMENT, AND THAT JILL DIAZ RECOMMEND THAT I SEE A PRIMARY HEALTHCARE PROVIDER FOR THAT SERVICE. I UNDERSTAND IT IS MY RESPONSIBILITY TO COMMUNICATE WITH JILL DIAZ IF I HAVE ANY QUESTIONS OR CONCERNS ABOUT MY SESSION.

ANY INFORMATION EXCHANGED DURING A SESSION IS CONFIDENTIAL. I UNDERSTAND I WILL BE ASKED QUESTIONS ABOUT MY HEALTH, EMOTIONS, AND MENTAL WELLBEING TO DETERMINE BEST PRACTICES FOR HEALING. I AM OBLIGATED TO ANSWER TRUTHFULLY AND HONESTLY ABOUT MY HEALTH HISTORY.

I ACKNOWLEDGE THAT I AM RESPONSIBLE TO BE ON TIME FOR MY APPOINTMENTS. I UNDERSTAND THAT MY APPOINTMENT TIME IS BOOKED FOR ME. IF I AM UNABLE TO GIVE A 24 HOUR CANCELLATION NOTICE, I MAY BE CHARGED A FEE. I UNDERSTAND IF I AM LATE THAT IT MAY EFFECT OTHER CLIENTS AND JILL DIAZ MAY NOT BE ABLE TO EXTEND MY APPOINTMENT TIME.

I UNDERSTAND THAT JILL DIAZ DOES NOT PRESCRIBE PHARMACEUTICALS.

I UNDERSTAND THAT SERVICES OFFERED TODAY, AND OR IN THE FUTURE, ARE NOT A SUBSTITUTE FOR MEDICAL CARE AND THAT ANY INFORMATION OFFERED IS PURELY FOR EDUCATIONAL PURPOSES AND IS NOT DIAGNOSTICALLY PRESCRIPTIVE IN NATURE.

I HAVE STATED ALL OF MY KNOW MEDICAL CONDITIONS ON THE HEALTH SURVEY. I HAVE CONSULTED A MEDICAL DOCTOR OR LICENSED MEDICAL HEALTH CARE PROFESSIONAL REGARDING ANY DISEASE OR CONDITIONS.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KEEP Jill Diaz UPDATED ON ANY CHANGES IN MY PHYSICAL AND MENTAL HEALTH AS LONG AS I AM A CLIENT.

I HAVE REVIEWED THIS FORM IN ITS ENTIRETY AND I HAVE DISCUSSED ALL MY CONCERNS.

SIGNATURE: _____ DATE: _____