ESSENTIAL WELLNESS
CLIENT INFORMATION FORM

Whitney Jones & Jennifer Christopher
BBRE Practitioners

For your first visit, we recommend that you bring in all supplements and prescription medicines that you are currently taking.

PERSONAL INFORMATION

Name _____ Date _____

Preferred Name _____

DOB _____ Age _____

Street Address _____

City, State, Zip _____

Cell Phone _____ Other Phone _____

Email Address _____ Referred by _____

Name of Medical Doctor _____ Phone _____

EMERGENCY CONTACT

Name _____ Relation _____

Phone _____

EMPLOYMENT INFORMATION

Employer Name _____

Occupation _____ How long? _____

Address _____

City, State, Zip _____

TO THE PATIENT

Please list the five main concerns / complaints you have, in order of your importance.

1. _____
2. _____
3. _____
4. _____
5. _____

_____ I understand that I am here to learn about nutrition and better health practices, and that I will be offered information about whole-food supplements and herbs as a guide to general good health. I fully understand that those who counsel me are not medical doctors and I am not here for medical diagnostic purpose or treatment procedures. The services performed here do not involve the diagnosing, treatment or prescribing of remedies for disease. Nutritional supplements are intended to support the body and are not intended as a cure or treatment of any disease.

_____ I understand that I should not discontinue any prescription medicines without the consent and knowledge of my medical physician.

_____ I understand that I am responsible for my scheduled appointments.
As a courtesy, Essential Wellness will set up text or email reminders. However, in the event that I am not reminded of an appoinment, I remain financially responsible.

_____ I understand that payment is expected at time of service and I will be charged in full for any missed appointments. Insurance does not cover any services provided at this office by Whitney Jones or Jennifer Christopher.

_____ I understand that, unless there is an emergency, a 24-hour notice is required for any cancellation of appointments. Otherwise, I will be subject to payment in full for the cancelled/missed appointment.

Print Name _____ Signature/Responsible Party's Signature (if a minor) _____ Date _____

CREDIT CARD PAYMENT FOR PROFESSIONAL SERVICES
(Please note the following information is necessary to book your appointment)

___ VISA ___ MasterCard ___ AMEX ___ Discover

Name on Account (exactly as it appears on credit card)

Billing Address (if different from 1st page)

City State ZIP

Credit Card Number Exp. Date Security Code

I authorize Essential Wellness to bill the above credit card for professional services or missed appointments in accordance with policies described above. I will notify Essential Wellness in writing if I no longer want my credit card billed.

Name _____ Date _____

Information discussed in session is confidential. We are ethically bound to protect this confidentiality. There are instances when a practitioner must disclose information about a client:

1. At the Client's Request: when you sign a written release expressing consent to disclose information to a specific individual or organization.

2. Clear and imminent danger: if disclosures in a session reveal an immediate threat of danger to you, another person, or the property of another person, confidentiality is outweighed by an ethical obligation to prevent harm.

3. Court order / subpoena.

This is acknowledgment of receipt of Notice of Privacy Practices from Essential Wellness.
I understand that my protected health information may be used by the Practice as described in the notice.

Name (Please Print) _____

Signature _____ Date _____

Responsible Person (if client is a minor) _____

Office Use Only

I made a good faith effort to obtain patient/responsible person's signature in acknowledgment of Notice of Privacy Practices from Essential Wellness, but was unable to do so as documented below.

Date _____ Staff Signature _____

Reason _____