PHOTON SOUND BEAM THERAPY INTAKE FORM

Please complete the following questions carefully.

How Did You Learn About Our Services?

Personal Referral ___ Doctor/Practitioner ___ Print Ad ___ Internet ___ Yellow Pgs ____ 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: _____________________

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

____

2. Doctor's name____ Phone: ________________________

3. Top health concerns: ____

____

4. List all medications & supplements you now take regularly (including over the counter) _________________

____

____

5. List all known allergies: ____

____

6. How much **water** do you drink per day? __________________ (**Source**: *tap, bottled, filtered, boiled)*

7. **Exercise:** What kind of exercise do you do? ____

How often? _________________________ Duration? ____

8. **Energy**: Please rate your normal energy level on a scale from 1-10:
(10 = "optimal energy " - 1 = "can't get out of bed") ________________

9. **Diet:** What type of diet best describes your general **dietary habits**
Circle best response: *junk food/fast food eater, vegetarian, vegan, macrobiotic, health conscious, natural food eater (over 50% organic), combination (from junk food to health conscious)*

10. What do you hope to achieve from this appointment for photon sound beam therapy? _________________

____

Signature: ____ **Date:** ____________________

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

FINANCIAL & CANCELLATION POLICY AND RELEASE STATEMENT

Full Session, Single (approx. 1 hr) ~ $60

Mini Session, Single (approx. ½ hr) ~ $40

Missed Appointments ~ $30

Full Session, Series of 3 (Pre-paid) ~ $165

Mini Session, Series of 3 (Pre-paid) ~ $105

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. The above prices are subject to change. ***There may be times when promotional prices are offered.*** Packages must be used within 1 month from the time of purchase.

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 of $30 for the missed appointment. (Special circumstances are considered on a case by case basis).

Contraindications: Photon Sound Beam
We do not recommend the use of the Photon Sound Beam Generator by individuals:

- with cardiac pacemakers
- who are or suspect that they may be pregnant

Disclaimer: the Photon Sound Beam is not a medical device. It is not intended for the diagnosis, prevention, treatment, cure or mitigation of any disease in humans or animals. It is not designed to affect the structure or function of any system in the body. If you have a health-related condition that requires medical attention, always consult with a licensed health care professional. Any individual results may vary.

I acknowledge that Gentle Pathways, and all staff members are not medical doctors. 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 advanced 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 and Marian Bauman-O'Dell, Heart Song Counseling and Healing 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)