Dr. John Douillard, D.C., Ayurvedic Consults

DISCLOSURE AND RELEASE AND WAIVER OF LIABILITY AGREEMENT

I, the undersigned (client), acknowledge that I have read and understood the contents of this agreement.

1. Dr. John Douillard, D.C. and LifeSpa Professional LLC make no representations, claims, or guarantees regarding the efficacy of his recommendations. The recommendations are based upon a combination of his clinical experience in the state of Colorado and knowledge of natural health literature. A natural health consultation as provided by Dr. John Douillard D.C. does not constitute a medical service or health care treatment.
2. I also grant permission to John Douillard D.C. to perform such examinations and therapeutic treatments as are considered necessary or advised for my diagnosis and treatment plan. I understand that I may look at my medical record at any time and may request a copy of it. I understand that the nature of the recommended treatments for my care will be explained to me and that I will have the opportunity to ask questions of those involved in my care. I am not being forced to accept treatment.
3. The title of "Dr." is used to indicate the achievement of a Doctor of Chiropractic degree and does not imply that Dr. John Douillard is licensed to practice medicine in the state of Colorado. Dr. John Douillard D.C. maintains a license to practice chiropractic in Colorado because there is no license to recognize Ayurveda in the United States.
4. 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 health condition(s). For example, in the case of children I advice that you seek the advice of a pediatrician; if you have cardiovascular disease, consult with a cardiologist; and if you have cancer, consult with an oncologist, etc.
5. 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.
6. Financial Policy: Patients are fully responsible for all professional services, herbs, supplements, or equipment received. We are not contracted with insurance companies and do not bill for services. We are able to provide you with an insurance superbill with appropriate diagnosis and procedure codes and a receipt that you may submit for reimbursement. I, the undersigned, understand that I am responsible for all charges. I understand that failure to pay is illegal.
    a. We will collect full payment for any nutritional supplies, supports, and any therapeutic appliances the day they are prescribed.
    b. We will charge a $25 fee for any returned checks.
    c. Office Visit Cancellation: We require a 24-hour (business days) advance notice of an office visit cancellation. There is a 50% fee for visits not cancelled 24 hours (business days) in advance.
7. Supplements: Dr. John Douillard D.C., LifeSpa Professional LLC, and LifeSpa Products LLC make available nutritional supplements and other health products. You are in no way obligated to purchase these products from this office or any other specific location or company. You may freely choose to purchase such products from any source(s) as you wish.
8. Follow up: It is the responsibility of the client to follow up for results of all testing and laboratory procedures. It should not be assumed on the part of the client that if they are not contacted by LifeSpa Professional LLC or if the patient does not schedule or keep a consultation, that test results are normal (or without abnormalities), and may not require further medical treatments or advice. Health/medical recommendations and/or possible referral and additional follow-up may be warranted based upon laboratory testing and evaluations.

By typing or printing my name in the signature field below (which shall constitute my signature), I agree to comply with the above polices and acknowledge that I understand all terms, verbiage (language) and concepts herein. ***I understand this consent agreement and have executed it freely and willingly.***

_____	_____
Sign or Type Signature (Patient or Guardian)	Date
_____	_____
Print Patient's Name	Print Guardian's Name