Healthy Foundations
A great place to start

CONSENT FOR TREATMENT

Healthy Foundations Inc. is a holistic wellness center that utilizes a Electro-Dermal Screening method which is not licensed by the state of Illinois. Electro-Dermal Screening (EDS) is an amazing technology, which allows the practitioner to assess what energetic imbalances are going on within the body. EDS can detect which organ systems, glands, hormones, neurotransmitters, enzymes or metabolic processes are producing stress.

At Healthy Foundations, your Holistic Healthcare Practitioner, (HHP), will work with you to achieve realistic health goals. A treatment plan will be developed by your HHP using supplements your body tests well for optimal health and healing. Most of these supplements are not meant for our clients to be on indefinitely, but only until the body returns to a balanced state (homeostasis).

As our client you should expect the Initial Evaluation to take approximately 1.5 to 2.5 hours, depending on the complexity of your health challenges. Follow-up appointments are usually made 4-8 weeks from the Initial Evaluation, and last 30 minutes to 1.5 hours in length. Utilizing Electro-Dermal Screening to assess imbalances and chose remedies, along with a proper dietary regimen including healthy lifestyle modifications (including an appropriate dietary regimen, an effective exercise program) can have a beneficial influences in a multitude of health challenges. Clients who experience the best outcomes are motivated to get well, consistent with their treatment plan and make healthy lifestyle choices.

At no time will any practitioner at Healthy Foundations recommend that you stop taking any your prescription medications without referral to your prescribing physician. Additionally, any supplements you have been recommended to use by another health professional will be evaluated and you will be referred back to discuss the value of continuing those remedies. Evaluation of the individual biocompatibility and effectiveness of any supplement or medication will be addressed as part of the bio-energetic assessment.

Our Prices for services are listed below:

Initial Evaluation (5 and under)	$200.00
Initial Evaluation (6 and over)	$300.00
Initial Evaluation Complex (more than 3 hours)	$350.00
Routine Follow-up (30 min to 1 hour)	$150.00
Short Follow-up (15 min appointment)	$50.00

Please Initial each of the following statements to confirm your acceptance:

_____ Healthy Foundations requires a 48 hour notice of any appointments that need to be rescheduled or cancelled. A cancellation fee of $150.00 will be charged to the card that was used to secure the appointment.

_____ We are a cash practice and do not file or submit insurance claims. Healthy Foundations no longer accepts HSA / Flex Spending Accounts, because these accounts now require a prescription by M.D. for any supplements to be covered. Since we DO NOT diagnose any Medical Conditions, we are not able to provide any diagnosis codes for clients to submit for reimbursement.

_____ We require payment at the time of service. We accept personal checks,VISA, MasterCard, Discover and AMEX.

_____ As a Healthy Foundation client, all calls, emails, texts will be returned within 24-48 hours. The best way to contact one of us is to ideally, text, email or call in that order. All phone messages, will be returned between the hours of 10am and 5pm that same day or by the end of the following day, except on Saturdays and Sundays.

Text any questions you have regarding your treatment protocol or issues you are experiencing to Mary (224) 628-1246 Email us any questions you may have to:

kerry@yourhealthyfoundations.com or mary@yourhealthyfoundations.com

To order products please use our website link on the homepage of our website www.yourhealthyfoundations.com or email your order to orders@yourhealthyfoundations.com
To inquire about our services please email us at info@yourhealthyfoundations.com

To schedule or change an appointment time, call our office at (847) 963-6094

To share any medical records or send important documents please FAX them to (847) 963-6098

I acknowledge the above statements.

SIGNED _____ DATE _____

PRINT NAME_____

(IF MINOR: PLEASE SIGN BELOW)

GUARDIAN'S
SIGNATURE_____RELATIONSHIP_____

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CANCELLATION POLICY

The creation of this cancellation policy has been necessitated because of last minute cancellations by some scheduled clients. When clients do NOT show up or cancel appointments for non-emergency reasons less than 48 hours before their scheduled time, not only does our practice lose money, but clients who are on a waiting list to get in earlier are not afforded that opportunity. We need at least 48 hours to contact and hear back clients who would very much appreciate and benefit from being able to get in earlier to see us. There is generally a 3-4 week waiting list for new clients to get in for an appointment, and would greatly appreciate your cooperation in this matter. Many practices like ours have instituted similar cancellation policies. We greatly appreciate you carefully reading, initialing and signing this policy.

1. In the event that you need to cancel and/or reschedule an appointment for a non-emergency reason, you will call and leave a message at our office (847) 963-6094, at least 48 hours in advance of your scheduled appointment. _____ INITIAL HERE.

2. Cancellations for emergency reasons are excluded from the above policy. Emergency reasons include accidents/death in the family, sudden sickness of self or immediate family member, flight delays or cancellations when you are arriving at the airport. _____ INITIAL HERE.

3. If you do not show for your scheduled appointment, or cancel for a non-emergency reason less than 48 hours prior to your appointment, a cancellation fee of $150.00 will be charged to the card that was used to secure the appointment.

I, (PLEASE PRINT NAME) _____INITIALS_____

I have read and agree to comply with the above policy.

SIGNATURE_____ Date: _____

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NEW PATIENT FORMS

Name:_____

Address:_____

City:_____State: _____ Zipcode: _____

Home Telephone: (With Area Code)_____

Work Telephone: (With Area Code)_____

Cell Phone: (With Area Code)_____

E-Mail Address:_____

Date of Birth:_____

Marital Status: Married Single Divorced Widowed

Name of Spouse:_____

Number of Children: Boys:_____ Ages:_____ Girls:_____ Ages:_____

In case of emergency contact:

Name:_____

Relationship:_____

Telephone: (With Area Code)_____

Who referred you to Healthy Foundations?_____

Chief Complaint – What is the main reason you are seeking care at Healthy Foundations?

_____

_____

Duration of present condition?_____

What do you believe caused this condition?_____

_____

Your Primary Care Physician's Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone: (With area code)_____

Diagnosis by your Physician?_____

Medications you are currently taking:

1.	5.
2.	6.
3.	7.
4.	8.

What methods do you use to alleviate or cope with stress?_____

Do you suffer from exhaustion or fatigue?_____

List Supplements or over-the-counter drugs you are currently taking:

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

Do you use the following?	How much how often?
Coffee	
Tea	
Alcohol	
Chocolate	
Cigarettes	
Laxatives	
Sugar	
Artificial Sweeteners	

List any foods you crave:_____

_____

List any known allergies to either food or drugs:_____

_____

Do you have any other special dietary restrictions?_____

Do you have a pacemaker?_____

List any recent hospitalizations or surgeries:_____

_____

Any unusual childhood diseases?_____

Is there a family history of any of these diseases?

	Mother's Side	Father's Side	Siblings
Allergies:			
Arthritis:			
Asthma:			
Cancer:			
Diabetes:			
Heart Disease:			
Kidney Disease:			
Liver Disease:			
Lung Disorders:			
Mental Illness:			
Substance Abuse:			
Stomach Disorders:			
Other:			

Feel Free to share any additional Medical information and or health concerns with us:

Please share your health care goals for treatment at Healthy Foundations?

What expectations do you have for your treatment at Healthy Foundations?