Patient Intake

Name		Date:
Address:		Birth Day:
City:	State:	Zip:
Phone:	Cell Phone:	
E-mail		
Reason for Visit (what would you like addressed?):		
Symptoms/Conditions:		
Medication/ Vitamins/ Skin Care Products/ Implants/ Pacemakers:		
Diet:		
Weight Current:	Ideal:	
Diagnosis:		
1.		
2.		
3.		
Treatment:		
1.		
2.		
3.		

I am requesting health or beauty related services and or products from you without having received from you any oral or written promise that these health products or services will have health benefits for me in the treatment of any disease or condition I may have. I hereby agree to release and hold Teresa Rispoli, or any of her employees harmless from any all liability claims, damages or causes of action arising from or related to pre-existing conditions which I may have.

I understand that a 24 hour notice of cancellation is required or I will be charged the full cost of the treatment. I have read and understand the foregoing and voluntarily consent to the terms and conditions contained herein. I understand that thee is a charge for the consultation and a no refund policy in effect.

Signature: Date: