Visionary Health Medical Educational Clinic (VHMEC)
5359 Dundas St West Unit 108, Toronto, ON M9B1B1 647-478-9029 FAX: 647-557-3323
vhmec108@gmail.com info@vhmec.com www.vhmec.com

HEALING with Heart Circle Intake Form

First Name: _____ Last Name: _____ Date of Birth (MM/DD/YYYY): _____

Address:_____ City:_____ Postal Code: _____ Phone: _____

Email: _____ Emergency Contact: _____

Pre-Session Evaluation Date: _____
1. How do you feel today?
2. What symptoms do you have (*please rate from 0-being the lowest to 10) a) Physical Health _____ b) Mental and Emotional Health_____ c) Spiritual and Social Health_____
3. What medications are you taking/any surgeries?
4. How "good" do you feel overall (*please rate 0-10)?
5. Have you noticed any changes since your last visit that you would like to share (if applicable)?

Post-Session Evaluation Date: _____
1. How do you feel at the end of your session?
2. Do you have any symptoms (*Please rate 0-10)? a) Physical Health _____ b) Mental and Emotional Health_____ c) Spiritual and Social Health_____
3. How "good" do you feel now?
4. In what way do you feel we can further assist you?
5. Comments/feedback?

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INFORMED CONSENT- Healing with Heart Circle

I,_____, understand that I will be participating in a healing circle at Visionary Health Medical Educational Clinic (VHMEC), 5359 Dundas St West, Unit 108, Toronto, Ontario, M9B 1B1 or a virtual healing session.

By signing this agreement, I acknowledge all items listed below and that the nature of the healing has been explained in full to me, that any questions I have pertaining to the healing experience have been addressed, and that I am free at any time to request further clarification prior to the and during the healing. I am also aware that I may revoke this agreement/consent at any given time with written notice prior to the healing.

The healing session will be comprised of various VHMEC formally trained health and wellness practitioners as well as others who are trained in various healing modalities.

Full name, email address, home address, DOB and phone number, a client file will be provided to VHMEC and stored by another licensed provider with our current medical records.

I fully understand, this healing session/experience is in no way affiliated with services rendered at VHMEC, and that I may continue with any services provided with any practitioner and follow the consent of the services provided thereafter.

I consent, that the healing session does not provide any guarantee of healing outcomes.

I acknowledge that I am fully responsible for my own health and well-being and that no practitioner or VHMEC shall be held liable for any loss or damage, direct or indirect, incidental, special, consequential, or punitive damages. As such, I agree to indemnify, defend, and hold harmless any practitioner or VHMEC from and against any claims, losses, damages, obligations, costs, actions or demands.

I am aware I can reach to a practitioner, at any point following the healing session to address any questions, issues or continued care.

Date:
Client Signature

Date:
Witness signature

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CREDIT CARD AUTHORIZATION

By completing this form (please print clearly in dark ink), you are authorizing Visionary Health Medical Educational Clinic (VHMEC), to charge the credit card number provided for services and follow-ups.

We accept VISA or MasterCard. A copy of the completed transaction will be forwarded to you via email or by text (phone) on file (in accordance to our service provider).

Please note that if your credit card is declined, you will be charged an additional **$25 administration fee.** A copy of the completed transaction will be forwarded to you via email or by text (phone).

Full Name: _____

☐ VISA ☐ MasterCard

Card #: _____

Expiry: _____/_____ VC code: ____/____/____

Name on card:_____
(If different from above/ pre-authorization and agreement with clinic manager needed)

I authorize VHMEC to charge the amount of services rendered and completed, to my credit card, payment of ☐ $150.00 for the service.

Other amount(s) to pay, in accordance individuals' financial situation, under the individual's personal discretion.

☐ $50.00 ☐ $100.00 ☐ $150.00 ☐ Other _____

Cardholder's Signature:_____ Date: _____