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

Axitonal Alignment Intake Form

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

Address:_____City:_____Postal Code:_____

Phone: _____ Cell: _____ Email: _____

Emergency Contact:_____ Occupation:_____

Doctor's Name & Contact:_____

How did you hear of Visionary Health? _____

Please list your health concerns/Intentions for today:

_____

Are you currently being treated by any other physician(s) or healthcare practitioner or specialist? □Yes □No
If yes, please elaborate.

_____

Are you currently taking medications: □Yes □No
(Please list all of your prescription and non-prescription medications including birth control and aspirin, etc.)

_____

Are you currently receiving other alternative treatments? □Yes □No If yes, what type ie (Homeopathy, acupuncture etc?

_____

Do you or have you ever suffered from seizures of any sort? □Yes □No If yes, please elaborate

_____

Do you or have you ever suffered from seizures of any sort? □Yes □No If yes, please elaborate

_____

Are you okay being touched "appropriately" during the Alignment session or do you prefer not to be touched at all?
Touch is okay □ prefer not to be touched □

INFORMED CONSENT- Axitonal Alignment

TO THE CLIENT: You have the right, as a client, to be informed about the recommended procedure to be used so that you make an informed decision whether to undergo the recommended procedure(s) after knowing the benefits and risks involved. This document is not meant to alarm you; it is simply to inform you.
If you refuse any special procedure this will not affect your receiving other care or future treatments.

- I understand that the course of care, therapy may include the use of multiple modalities or therapies offered by Beatriz Marin at the 5359 Dundas St West Unit 108, Toronto, Ontario, M9B 1B1.
- While it can be used entirely on its own, it is not meant as a substitute for medical, or psychological, diagnosis and treatment. In fact, it can readily compliment other forms of therapy.

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- Practitioners do not diagnose conditions, nor do they perform medical treatment, prescribe substances, or interfere with the treatment of a licensed medical professional, unless they have received training in such a licensed professional practice that supports this. (This type of skill is not a part of a normal certified Reiki training program).
- Should not compete with medical doctors and their treatments.
- Can be used together with any other form of medical, natural, or alternative therapy to compliment it.
- I understand that my verbal consent to a specific treatment and my willing participation in receiving these therapies after explanation of benefits and risks is sufficient to indicate my consent to receive therapies.
- I waive the option of signing consent to treat for each special procedure at each treatment date.
- I understand that I am free to pursue other medical opinions and treatments including conventional medical care at any time.
- I understand that I have the right and the opportunity to ask questions about my condition & discuss therapies
- I understand that there is payment for today's treatment, and subsequent follow-ups, at the time of service accordingly to the fee schedule or plan.
- I understand that a phone consultation fee may apply.
- I accept that a missed appointment Fee of $50 will be charged and any missed appointments or cancellations within 24 hours of the appointment and that all outstanding invoices will need to be paid before the next appointment.
- I understand that no warranty or guarantee regarding a promise of cure as a result of care is provided for any condition.
- I understand that a record will be kept of the health services provided to me and will be kept confidential.
- I give consent and authorize Visionary Health Medical Educational Clinic practitioners to be contacted in the near future, for continued care.
- I understand that in the event there is a chance that media, audio or visual or published information, all of which I am consenting that Visionary Health Medical Educational Clinic be able to use and will be informed to their best practices ethics.
- I authorize Visionary Health Medical Educational Clinic team to contact me for educational events, promotions, incentives, newsletters, engagements, or information regarding of any health benefit.
- I certify that I have read this form or have had it read to me, and that I understand its content and meaning. I have sufficient information to give this informed consent.

Note: It is recommended you see a licensed physician or licensed health care professional for any physical or psychological ailment you may have.

Patient Name (please print): _____

Patient Signature: _____ Date:_____

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