ananda
yoga & healing arts center

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Anne Finan, MS, Director
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DISCLOSURE

Anne Finan, MS, provides professional nutritional and wellness counseling to those seeking complementary approaches for improving their health. Ms. Finan encourages clients to seek regular medical attention from their primary health care providers who may choose to participate in a cooperative team effort integrating complementary support towards achieving the client's wellness goals.

Nutritional consultation services may not be covered by your insurance company. Prospective clients therefore, are personally responsible for full payment of consultation services which must be received prior to scheduled appointments. Patients are also required to give 24 hour advance notice before canceling or rescheduling an appointment. If adequate notice is not given than Anne Finan reserves the right to charge the client for the appointment fee. All package consultations of 4-6 sessions are to used within a 4 month period. Allowance is made always for emergency situations.

COMMITMENT STATEMENT

I, _____(please print) have read and fully understand the aforementioned disclosure. I acknowledge that no guarantees have been made to me as a result of treatment or evaluations by Anne Finan. By signing below, I acknowledge that any dietary or supplemental suggestions made by Anne Finan, are entirely nutritional in nature and are not intended to diagnose, cure or treat any disease or ailment. I also acknowledge that my physician is my primary health care provider, and is responsible for supervising all changes in diet and nutrient intake that I make. In consenting to do the detox cleanse program, I understand that I take full responsibility for the outcome and any side effects that might occur. This form will also serve as consent to use or disclose my protected health information to carry out treatment, payment activities, and healthcare consultations.

_____ FOR _____
Signature of Patient (minor's name)

_____ _____
Patient Name Patient Home/Work Phone

_____
Patient Address

_____ _____ _____
Patient Email Address credit card # expiration date

_____
date