

FIVE RIVERS HOMEOPATHIC CLINIC

HARPREET SINGH BHELA (HOM, DCHM)

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THINGS TO KNOW BEFORE THE APPOINTMENT

- We **CANNOT** proceed with the consultation without completed and signed intake forms.
- Consultations can be done **in-person, over the phone or video call**. If doing a phone/video consultation, please e-mail us the completed intake form **PRIOR** to your appointment.
- The initial consultation for chronic (long term/multiple) conditions can last upto **1 hour** and for follow ups and acute (short term/single) conditions approximately **45 minutes**.

FEE AND PAYMENT POLICY

- The fee for first visit is **\$125**. After that, each follow-up visit is **\$75**.
- There's a **\$15** fee for a typed summary report of the bio resonance testing.
- Most remedies are included in the consultation fee (except tinctures and supplements, if any)
- We only accept cash payments. Etransfers are accepted **ONLY** for long distance patients. The email for etransfer is fiverivers@keemail.me
- Many insurance companies now cover homeopathy. Check your policy for your eligibility.
- Your appointment slot is kept especially for you and cannot be easily refilled in a short frame of time. Please notify us at least one day ahead in case you are unable to attend your appointment. **ANY MISSED OR CANCELED APPOINTMENTS WITHOUT AN ADVANCE NOTICE MAY BE CHARGED 50% OF THE FEE.**

Medical/Professional Waiver

PLEASE READ THE FOLLOWING CAREFULLY (if under 19 years of age, a parent or guardian must sign.) I, the undersigned, understand that Harpreet Singh Bhela is a homeopath and not a licensed medical doctor. As such, I acknowledge that it is my responsibility to seek medical diagnosis and advice for my present and future conditions. In consulting with Harpreet Singh Bhela, I am exercising my right to choose an alternative method of treatment through which to address my total health. As homeopathy is not covered by the existing government medical insurance plan, I agree to pay all fees presented in the current fee schedule. I acknowledge that all personal information will be kept confidential.

DISCLAIMER FOR BIO RESONANCE

- Bio resonance therapy provides a completely non-invasive method for gaining valuable information about an individual's Innate Intelligence and/or energetic field. The primary objective of the evaluation is to disclose energetic imbalances and provide feedback that will assist in developing a program to support each physical and energetic system of the body.
- I understand that Bio resonance testing does not provide a medical diagnosis and that my testing technician may recommend further medical care and testing. If I suspect I need medical intervention, I understand I should consult MY physician. I give my permission for the testing technician to evaluate me with the Bio resonance testing device. I understand in doing so, my testing technician is NOT becoming my primary physician. I understand that the testing technician will give me information about my body's energetic field and make recommendations based on the Bio resonance test results. I understand that the testing technician will not pass judgments on prescribed medications and it is the responsibility of my primary physician to make any adjustments to prescribed medications or methods of treatment. Any decision to follow through with the recommended protocol is my own decision and I will not hold the testing technician liable.

- I understand that I am here to learn about natural health and better lifestyle practices, and I will be offered information about food, supplements, and herbs as a guide to supporting my well-being.
- I understand that I should continue to see any physicians I may be currently under the care of and that any prescribed medications should not be altered without first consulting the physician who prescribed them.
- I fully understand that those who counsel me may not be licensed physicians. I am not seeking any medical diagnosis or medical treatment in relation to the Bio resonance testing.
- I fully understand that information about traditional uses of supplementation that may support balance may be discussed. I fully understand that this information is not intended to be interpreted or used as a substitute for medical care offered by a licensed physician. I fully understand that anything said, done, typed, printed, or presented in any other fashion to me is not intended to diagnose, prescribe, treat, or take the place of a licensed physician.
- I fully understand that the intent is to provide educational information for the purpose of assisting me with the lifestyle changes necessary to regain and maintain an environment needed to support a well-balanced lifestyle.
- I am not on this visit, or any subsequent visit, acting as an agent for the federal, state, county, local law enforcement, or news media on a mission of entrapment or investigation.
- I understand that all information and conversations will be kept confidential, and that information concerning myself may only be released to a health professional with my written consent.
- I understand that the Bio resonance testing will only identify energetic imbalances and does not diagnose any diseases. The Balancing Item refers to the energetic signatures needed to restore balance to body's energetic field. Balancing Items are defined differently from physician terms and are not a cure for any disease.
- I recognize that the Bio resonance testing is an unorthodox approach to supporting my well-being. Being of sound mind, of my own free will and in exercise of my constitutional right for the attainment of life, liberty and the pursuit of happiness, I have chosen this evaluation method to assist in balancing my health.

Parent Signature: _____

Date: _____

Intake Form (Child)

Patient's Name: _____ Date of Birth: D ____ M ____ Y _____

Mother's Name: _____

Father's Name: _____

Address: _____

Street

City

Postal Code

Phone (Mother): _____ (Cell) _____ (Other) _____

Phone (Father): _____ (Cell) _____ (Other) _____

Email: (please write in CAPITAL) _____

How did you hear about us? _____