CLIENT INFORMATION

Please print and use black ink. Date________________________

Name____

Address____
Street *City* *State* *Zip*

Home phone (______)_______________ Business phone (______)______________

Fax (______)_______________________ Cell (______)_______________________

Email____

Occupation__________________________ Birth date________________ Age____

Weight________ Height________ Gender________ Single________

Married______ Divorced______ Widow(er)______ Number of children________

Date of last physical examination _________ Results __________________________

____

Morning underarm temperature (if known)__________ Blood type_____________

History of illness, accidents, and treatment ___________________________________

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____

Current physical complaints and medications I am taking ________________________

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____________________ How did you hear about us? __________________________

DISCLOSURE TO CLIENTS AND CONTRACT

Richard Loyd, Ph.D., and Health Balances agree to provide the client with health improvement information until such time as either Dr. Loyd, Health Balances or the client should choose to terminate this service.

1. I hereby authorize Richard Loyd, Ph.D. and his staff to provide me with health improvement information. To assist them in developing a program for me, I authorize them to perform certain tests. I understand that these tests are not necessarily approved by the conventional medical profession, nor the Food and Drug Administration, nor are these tests for the purpose of diagnosing any particular disease or medical problem.

2. I am here on this and any subsequent visit solely on my own behalf and not as an agent for federal, state, or local agencies on a mission of entrapment or investigation.

3. I fully understand that neither Dr. Loyd nor any members of his staff are licensed physicians or licensed practitioners of any kind and I am not here for medical diagnostic or treatment procedures. I am obtaining these from other sources. Rather, I understand that Dr. Loyd's program focuses on building general health through education.

4. I understand that the services performed by Dr. Loyd and his staff are restricted to consultation on matters intended for the building of general health, and do not involve the diagnosing, prognosticating, treatment, or prescribing of remedies for the treatment of any disease, injury, or other physical or mental condition, or any act which will constitute the practice of medicine in this state.

5. I have been advised by Dr. Loyd and his staff that if I have particular medical complaints, I should continue in the care of my physician or should consult a physician if I have not yet done so. I have also been advised that even if I believe that my physical or mental health has improved as a result of Dr. Loyd's suggestions, I should continue to comply with the medical treatment prescribed for me by my physician until my physician has told me that the treatment should be changed or discontinued.

6. I agree to indemnify (protect) and hold harmless Dr. Loyd, his staff, his relatives, and Health Balances in the case of any injury or death that might arise from the use of these services.

Signed____________________________ Print Name__________________________

Date___________________________

For Dr. Loyd/Health Balances ____________________________

Health Balances Phone/Fax 206-244-1383
10814 206th Street E.
Graham WA 98338