BRIGHT HEALTH AND WELLNESS 120 W. Germantown Pike Suite 210 Plymouth Meeting, PA 19462

Client Privacy

Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved directly and indirectly in that treatment.

- Obtain payment from third-party payers (if applicable)

- Conduct normal healthcare operations, such as quality assessments and practitioner certifications (if applicable).

I understand that I may request in writing that you may restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I understand that any information you send me via a Google email account, may not be completely safe and is subject to a third party retrieving my confidential information without consent of Rachel Bright, ND or myself, because it is being sent through the Internet.

I understand that I may revoke this consent in writing at any time, except to the extent that Rachel Bright, ND, BS, HHP has taken action relying on this content.

Client/Guardian Printed Name:

_____

Signature:

_____

Date

_____

AGREEMENT FOR CONSULTATION AND EDUCATION SERVICES

This agreement is between Bright Health and Wellness ("Practitioner") and the individual whose name and signature appears below ("I" or "the Client") or the legal guardian thereof (the "Agreement"). In consideration of the wellness services provided to the Client by Practitioner at the present and at all times in the future, I agree as follows (agreement is indicated by placing Client initials on the lines following each section and by signing in the space provided at the bottom of the page):

1. **Consent for Services:** I, _____, the undersigned, do hereby authorize and give consent to Practitioner to provide wellness consultation and education services ("Services") to the Client, which may include but is not limited to the following:

(a) General Assessment: Including, but not limited to wellness assessments.

(b) Lifestyle & Naturopathic Dietary Counseling: Including, but not limited to approaches to support health issues; allergies, bone health, cleansing and detoxification, homeopathy, digestive health, natural diet approaches (including gluten free diets), immune enhancement, women's and men's health, longevity and anti-aging, exercise plans, nutritional and herbal supplements, and counseling concerning sleep hygiene, stress reduction, and balance of life activities.

(c) Wellness Techniques: Including, but not limited to, ionic foot detox, neuromuscular technique, yoga techniques, energy therapies, imagery, and relaxation techniques.

I understand that neither Practitioner nor its employees, independent contractors or agents, including Rachel L. Bright, N.D., are licensed medical or osteopathic doctors. She does not diagnose, treat or cure any diseases. Her qualifications are only to evaluate in a holistic healthcare manner. I understand that Rachel Bright, ND is a Board-Certified Traditional Naturopath by the American Naturopathic Medical Certification Board, Doctor of Traditional Naturopathy, Certified Nutritional Practitioner and Holistic Health Care Practitioner. This form of an evaluation is not considered a medical diagnosis. For a medical diagnosis,

please see your physician. The Services being provided to me involve naturopathic wellness consultation and education and counseling and not the practice of medicine. I understand that any changes to my diet or lifestyle should be reviewed with my personal physician. (Initial)_____

Although general information may be provided regarding the relation of homeopathy, herbal remedies and naturopathy to general immune health and viruses, I understand that neither Practitioner, nor its employees, independent contractors, or agents, including Rachel Bright, N.D.(Traditional), will provide information regarding COVID or COVID vaccinations. For information regarding COVID and COVID vaccinations, I understand that I should consult my personal physician. (Initial)_____

I acknowledge that neither Practitioner, its employees, independent contractors or agents has made any guarantees or promises as to the outcome, the safety or the efficacy of the Services and that nobody has guaranteed, warranted, assured or otherwise promised me that the wellness and educational consultation services provided will cure, heal, remedy, resolve, or improve any disease, sickness, ailment, malady, disability, disorder, injury or bodily condition. (Initial)_____

2. **Information I Have Provided to Practitioner.** I hereby verify that I have provided Practitioner with a complete list of all prescription and non-prescription medications and substances I am currently or have recently been taking; and I agree to update such list whenever a change is made. I have also provided a list of all known allergies including medications, dietary/nutritional substances, and plant and animal substances. I have also provided a list of all medical, surgical and/or psychological conditions I currently have, and any such major conditions I have had in the past. The information I have provided, including but not limited to the information required by this Section 2, is true, accurate, complete and up-to-date to the best of my knowledge. (Initial)_____

3. **Right to Decline Services** . I acknowledge and understand that IT IS MY RIGHT TO DETERMINE THE EXTENT OF THE SERVICES TO BE PROVIDED HEREUNDER AND THAT I MAY DECLINE SERVICES AT ANY TIME BEFORE OR DURING CONSULTATION. (Initial)_____

4. **Miscellaneous.** I acknowledge that this Agreement constitutes the entire agreement between Practitioner and the Client regarding the subject matter hereof. No promise, representation, guarantee or warranty not included in this Agreement has been or is being relied upon by the Client. This Agreement shall be binding on the Client, his/ her successors, heirs, legal representatives and assigns. This Agreement shall be governed by the laws of the Commonwealth of

Pennsylvania without regard to any choice of law principal. (Initial)_____

5. **Financial Responsibility**. I acknowledge that all programs and consultations are my responsibility. In the event that my insurance plan, flexible spending account, health savings account, medical savings account or similar plan or account does not cover a program, consultation or other service, I am responsible for payment of these charges. (Initial)

6. **NO GUARANTEE OF RESULTS.** I recognize that this agreement is not a guarantee of results and deals solely with these services to be rendered and fees to be paid for the care as provided. My payment obligation is not contingent upon the outcome of care.

7. **Extended Health Coverage.** Rachel Bright's services are not billable. They may be covered under some HSA accounts, although not guaranteed. I have read and understand the information and policies presented. I intend for this consent form to cover the entire course of my recommendations as suggested by Rachel Bright, ND. I understand that I am free to withdraw this consent and discontinue participation at any time.

8. **Rachel Bright, ND is not necessarily expected to be able to anticipate and explain all the risks and complications from recommendations.** The client chooses to rely on Rachel Bright, ND to exercise professional judgment when deciding which recommendations will be in the client's best interest based on the facts known at the time. Natural Healthcare and
Conventional Medicine are not mutually exclusive and therefore, the client is free to and encouraged to seek or continue medical care from a qualified physician.

9. **Client records will be kept confidential** and will not be released to others without consent from both Rachel Bright and the client, unless required by law. Rachel Bright may share pertinent information with other Natural Healthcare Practitioners, MD's, Nutritionist, Herbalists, Chiropractors within her wellness field with the purpose of discussing the best course of treatment and to deliver safe and efficient care. Your personal information may be used to establish and maintain contact, communicate with other treating health-care providers, and to allow for efficient follow-up with treatment, billing and processing of payments.

10. **I understand that I could experience the following when using homeopathic remedies:**

1. Old and chronic symptoms may be stirred up temporarily. They can be uncomfortable to experience, but hence the word temporary. 2. Healing speeds differ at times (sometimes it is faster sometimes it is slower - but the body is always in a state towards healing) 3. Homeopathy has been shown to not interfere with any medications, supplements or herbs.

BY SIGNING THIS AGREEMENT, I INDICATE THAT I HAVE READ, UNDERSTAND AND AGREE TO ITS TERMS, THAT I AM THE CLIENT, GUARANTOR, THE CLIENT'S LEGAL REPRESENTATIVE OR GUARDIAN, OR LEGALLY AUTHORIZED TO SIGN THIS AGREEMENT AND ACCEPT ITS TERMS.

I agree to inform my practitioner immediately if:

* I am pregnant
* If I have any changes to my prescriptive medications
* If I experience any negative side effects

Client or Legal Guardian
Interpreter (If necessary)

Signature:

Print Name & Title of Witness / Print Name if not the Client Name / Title of Interpreter _____

Date Relations, if signed by other than Client:
_____

Bright Health and Wellness

Meetinghouse Business Center 120 W. Germantown Pike
Suite 210- Plymouth Meeting, PA 19462 Telephone: (610) 500-4940

Pediatric Intake

Birth to 12 Years of Age

Name (First, Middle, Last) _____
Date_____
Age _____ Date of Birth _____ Sex: M F
Mother or Guardian _____ Father or Guardian

_____
Address _____ City_____
State _____ Zip _____
Telephone (Home) _____

Are you:
Next of kin or other to reach in an emergency

_____
Relationship _____
Address _____
Telephone (Home) _____
Telephone (Work) _____
How did you hear about the clinic?

_____

What are your child's most important health
problems?_____
_____
_____

Medications

	now	past		now	past		now	past
aspirin	___	___	antibiotics	___	___	decongestant	___	___
tylenol	___	___	anti-histamine	___	___	ibuprofen	___	___
inhalers	___	___	asthma meds	___	___	topical steroids	___	___

_____ ___ ___ _____ ___ ___ _____ ___ ___
others
Allergies to medicines
_____

Medical History

___ chicken pox ___ scarlet fever ___ bronchitis ___ tonsillitis, no. of times

___ measles ___ pneumonia ___ rubella ___ ear infections, # of x's
___ mumps ___ frequent cold ___ eczema ___ asthma
___ croup ___ other
_____

X-Rays and Special Studies

when where results
electroencephalogram
_____
psychological evaluation
_____
hearing
_____
speech/language
_____

Injuries/ Surgeries/ Hospitalizations

_____
_____
_____
_____

Immunizations

___ measles ___ polio ___ MMR ___ small pox ___diphtheria
___ mumps ___ DPT ___ tetanus ___ influenza ____Others
Any adverse reactions to immunizations? (Please specify)_____
_____
_____

Family History

___ heart disease ___ diabetes ___ birth defects ___ cancer ___ mental illness
___ hypertension ___ arthritis ___ tuberculosis ___ allergies
___ hay fever ___ eczema ___ others
_____

Previous pregnancies by natural mother, miscarriages or complications:
_____
_____
_____
_____
Mother's age at child's birth _____
Mother's health during pregnancy:
___ bleeding ___ hypertension ___ illness ___ cigarettes, alcohol, drugs
___ nausea ___ diabetes ___ thyroid problems ___ physical or emotional trauma

Birth History

Term: full ___ premature ___ late ___ weight at birth _____

acne	Y	N	P	easy bruising	Y	N	P	joint pains	Y	N	P
anemia	Y	N	P	eczema	Y	N	P	motion/car sick	Y	N	P
bleeding gums	Y	N	P	excessive fatigue	Y	N	P	nervous	Y	N	P
bleeding tendency	Y	N	P	flat feet	Y	N	P	nightmares	Y	N	P
bloody urine	Y	N	P	frequent colds	Y	N	P	night sweats	Y	N	P
body/ breath odor	Y	N	P	frequent headaches	Y	N	P	no appetite	Y	N	P
burning of urine	Y	N	P	frequent urination	Y	N	P	nose bleeds	Y	N	P
canker sores	Y	N	P	gas	Y	N	P	sensitive to light	Y	N	P
chronic rash	Y	N	P	hair loss	Y	N	P	sleep problems	Y	N	P
constipation	Y	N	P	hearing loss	Y	N	P	sore throats	Y	N	P
cough	Y	N	P	heart murmur	Y	N	P	stomach aches	Y	N	P
cries easily	Y	N	P	high fevers	Y	N	P	unusual fears	Y	N	P

diarrhea	Y	N	P	hives	Y	N	P	vomiting spells	Y	N	P
dizzy spells	Y	N	P	jaundice	Y	N	P	wheezing	Y	N	P

length of labor _____
complications _____
As a baby, did your child have any of the following problems?

___ jaundice ___ diarrhea ___ birth defects ___ rashes
___ colic ___ fever ___ cerebral palsy ___ allergies
___ blue baby ___ seizures ___ birth injuries ___ other

Feeding: breastfed ___ how long? ___ formula ___ milk ___ soy ___
Age the child began: solid foods _____ sitting _____ crawling _____ walking _____ first words _____
Child's sleep patterns during the first year
_____
_____
_____

Symptoms

Please circle: Y = a condition your child has now. N = never had. P = has had in the past.

Any other condition not mentioned?
_____

Diet

Please describe your child's typical daily diet:
_____
_____
_____
_____
_____
_____
_____

Food intolerances (if known)
_____
_____
_____

_____ _____
Authorized Person's Signature **Date**