New Patient Agreement

Congratulations on taking this important and proactive step for your health! Together we will create a healing strategy specific to your individual needs. Please keep in mind that our services/assessments differ from the medical diagnostic testing you may be familiar with. The energetic imbalances detected during a Meridian Stress Assessment are not intended to replace or contradict treatment you may be receiving from your physician. Thank you for choosing Circle of Health as your Alternative Health Care provider.

1. **Appointment:** Please avoid using lotions on hands and feet, perfume or any scented products. Also, bring any supplements in original bottle as well as a list of medications.

2. **Confidentiality:** Respecting your privacy is very important to us at Circle of Health, all personal information that is collected in the course of professional treatments is considered highly sensitive and private, and shall not be shared. In an effort to prevent wrongful disclosure of information to anyone other than yourself, please provide your preferred telephone number and email address so that we may contact you directly.

Telephone number:_____

Email address:_____

3. **Cancellation of appointments:** Please note that a late cancellation or a 'no-show' prevents other patients from enjoying the benefits of our services; at the same time making it difficult for our employees to replace and re-structure appointments. If you must cancel or re-schedule your appointment, we **request at least 48 hours notice** by calling **905-371-3331** or emailing **reception@circleofhealth.ca.** We appreciate your consideration.

In the event of a cancellation with less than 24 hours notice or of a 'no show' appointment, Circle of Health reserves the right to charge 100% of the intended appointment fee.

4. **Financial Transactions:** In the case of after-hours supplement pick-up, postal delivery of supplements and/or for express service, for your convenience we are pleased to hold your credit card information securely on file.

Credit Card #:_____CVC# (last 3 digits on back of card)_____

Type: VISA ___ MasterCard___ Expiry date:_____

Should you have questions or comments about the practices outlined above, please don't hesitate to contact us.

Signature: **Date:**

_____ _____

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