

INFORMED CONSENT & CLIENT AGREEMENT



I _____ (or the client named below, for whom I am legally responsible) request and consent to receive care and treatment by Melissa Smith (**Practitioner**) from Be Healthy Group (**Business**) who is a qualified BodyTalk Practitioner and Kinesiologist under Australian law.

I am aware that the Business takes a holistic approach to wellness and disease and that the Practitioner assesses everyone as a whole and seeks to activate and support the self-healing mechanisms of the body. I understand that the Practitioner is not a medical doctor and that treatment I will receive is not intended to replace orthodox medical care or medical prescriptions.

I understand that different approaches and remedies may be used during my treatment depending on my individual circumstances. These include, but are not limited to: essential oils, personalised food recommendation and lifestyle prescriptions.

I understand, and am informed, that there are potential risks and benefits to these remedies or treatments including but not limited to those described below:

Possible risks include but are not limited to: inconvenience of lifestyle changes, aggravation of pre-existing symptoms during the healing process; allergic reactions to prescribed remedies, side effects of natural medications such as gastrointestinal disturbance, rashes, headaches, and hypertension.

Potential Benefits include but are not limited to: relief of pain and symptoms of disease; weight loss, restoration of health and the body's maximum functional capacity, assistance in injury and disease recovery, correction of nutritional deficiencies, and prevention of disease and/or its progression.

I understand the importance of taking my prescribed treatment and remedies according to the prescription and will contact the Practitioner if I have any questions or concerns. If I suffer any allergies, unpleasant symptoms or reactions from the remedies, I will cease taking them and will immediately contact the Practitioner for further instructions.

I do not expect the Practitioner to be able to anticipate and explain all possible risks and complications. I wish to rely on the Practitioner to exercise judgement during the course of treatment, which the Practitioner feels at the time, based upon the facts known, is in my best interests. I understand that results or specific outcomes are not guaranteed.

I agree to inform my Practitioner:

- of any medical conditions or diseases, I have or may be suffering from (including any contagious diseases contractible by blood such as HIV, hepatitis);
- of all supplements and medications that I am taking (including any change in medications or dosages during the treatment period);
- of any vaccinations (including booster vaccinations) I have received in the two weeks prior to initial treatment or at any time during the treatment period;
- of any known or suspected allergies or sensitivities;
- if I am vegan or vegetarian (as I am aware that some supplements may contain animal products);
- if I am, or suspect I am, pregnant, trying to fall pregnant or breastfeeding, as certain treatments may be contraindicated.

I also agree it is my responsibility to inform my GP, pharmacist, counsellor or other health professional of the treatments and remedies I am taking.

I understand and consent to the collection of my personal information (including my health information) by the Practitioner for the purpose of providing treatment, and for other related purposes. I understand the collection, use, storage and disclosure of my personal information will be in accordance with Australian Privacy Laws and the Business's Privacy Policy available at:

www.behealthygroup.com.au/uploads/3/2/0/4/32042283/be_healthy_group_privacy_policy.pdf

By providing my consent, I am also consenting to the Privacy Policy and collection of my personal information for such purposes.

By voluntarily signing the below, I acknowledge that I have read the above, and I have also had the opportunity to ask questions about its content. I intend this consent form to cover the entire course of treatment for my present condition, and for future condition(s) for which I seek treatment. I understand I can withdraw my consent and/or discontinue treatment at any time upon notice to the Practitioner.

(Client/client's representative signature)

(Date)

Indicate relationship if signing on behalf of patient (i.e. parent): _____

(Printed name of client/client's representative

(Date)
