Client Statement

I hereby attest to the following:

1. I give permission to HELEN KAY COX and other personnel operating out of OPTIONS CENTER FOR HEALTH AND EDUCATION to perform the evaluation procedures they deem necessary at OPTIONS CENTER FOR HEALTH AND EDUCATION.
2. I fully understand that HELEN KAY COX and other OPTIONS personnel are not medical doctors or practitioners, do not diagnose or treat disease, and that I am not here for medical diagnostic or treatment procedures.
3. The services performed by HELEN KAY COX and other OPTIONS personnel, whether in person or by mail or telephone, are at all times restricted to consultative matters intended for the maintenance of the best possible state of health and education and do not constitute diagnosis, treatment, or prescription of remedies for the treatment of disease.
4. I understand that it is my constitutional right to decide how I wish to care for the health of my body and the education of my mind. HELEN KAY COX or other OPTIONS personnel have not suggested that I cease current medical care I am receiving, be it drug therapy, X-ray treatments, chemotherapy, surgery, or any other medical procedures that my medical doctor deems necessary for my health. If I choose to not follow the recommendations made by my medical doctor, I understand that such a decision is my responsibility and will not hold HELEN KAY COX or any other OPTIONS personnel responsible for any consequences of such a decision.
5. I am here, on this and any subsequent visits, solely on my own behalf and not as an agent for federal, state or local governmental agencies on a mission of entrapment or investigation.
6. I hereby agree to pay to Helen Cox, d/b/a Options Center for Health & Education, any and all sums incurred by me for services rendered by Helen Cox and/or any and all agents of Options, and for goods and products purchased at Options Center from this day forward. I promise to pay interest at the rate of 24% APR monthly on any sums owed to Options for more than 30 days. I also agree to pay any and all collection fees, court costs, and attorney's fees incurred in collecting any overdue amounts.
7. I agree to pay for all my herbs, vitamins, and services the day I receive them with cash, check or credit card. If I know I will be unable to pay on that day, I will make arrangements prior to that day.
8. I understand the sessions are 50 minutes in length, and if I am late the ending time will remain the same.
9. I will return any borrowed tapes and books within two weeks, and if any items are not returned in 1 month or are damaged, I will pay $2.50 per audio tape, $10 per video tape and $20 per book and $20 per audio set.
10. I understand that, due to liability concerns, I must have a consultation session with the Director, Helen K. Cox, RN, BSN, LDN, to receive an interpretation of any laboratory test results and to obtain my copy of the report.
11. I understand that any functional test kits purchased by me (saliva, urine, and stool) must be submitted to the lab within six months of purchase date or returned to Options for credit. To receive credit for purchase amount, kit must be returned intact with signed instruction sheet. After six months no credit will be given.
12. If I must cancel an appointment, I agree to call 24 hours prior to my scheduled time. If I cancel later than that or do not show for a scheduled appointment, I agree to pay the usual amount for the appointment; and I understand I may be requested to prepay future scheduled appointments. Please call between the hours of 8:00 AM-6:00 PM

I HAVE READ THE ABOVE POLICIES AND AGREE TO ABIDE BY THEM.

I understand Options may contact me to confirm my appointment one working day prior to my appointment. Contact me at: (Home ❑ Yes ❑ No) (Work ❑ Yes ❑ No) (Cell ❑ Yes ❑ No) (e-mail ❑ Yes ❑ No)

Please print the following:

Name: _____ Business Phone:_____

Address: _____ Home Phone: _____

_____ Fax Number: _____

City State Zip code

Birth Date: _____ Mobile/Cell Phone: _____

Signature: _____ Today's Date: _____

E-mail address [please print clearly]:_____

Referred by:_____Address:_____

May Options Center, Inc. send a Thank You note to the person that referred you? ❑ Yes ❑ No

Child's Name (if bringing child): _____ Birth date: _____ Relation to Child: _____

For Office use only: ___MMSWIN ___QB ___SalesContact ___Coupon ___ThankYou ___Office2Contact ___ HelenContact ___ MailChimp ____ Health HdbkPt1
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