

Client Statement

I hereby attest to the following:

Services Provided:

1. I give permission to Helen K. Cox and personnel operating through Options Center for Health & Education, Inc. to carry out the evaluation procedures they deem appropriate within the scope of services offered by Options Center.
2. I understand that Helen K. Cox and other Options personnel are not medical doctors and do not diagnose, treat, or prescribe for disease.
3. I understand that the services provided by Options Center, whether by phone, email, mail, or other communication, are consultative in nature and are intended to support wellness, nutrition, prevention, and education.

Client Intent:

4. I understand that any decisions regarding medical care, diagnosis, treatment, medications, surgery, or other medical procedures remain my responsibility and the responsibility of my licensed medical providers. I understand that Options Center has not advised me to stop or avoid medical care recommended by my physician or other licensed provider.
5. I confirm that I am seeking services from Options Center for Health & Education, Inc. voluntarily and for my own personal benefit.

Financial Responsibility:

6. I agree to pay Options Center for Health & Education, Inc. for all consultation services, test kits, reports, supplements, and other products that I purchase.
7. Payment is due at the time services are provided or products are ordered.
8. All services and products are paid by credit card or debit card.
9. I authorize Options Center for Health & Education, Inc. to securely store my credit or debit card information through QuickBooks Payments and to charge that payment method for appointments, consultations, functional and laboratory testing, supplements and other products, shipping, cancellation charges, and other services or purchases that I request, receive, order, or agree to. I understand that this authorization does not establish an automatic recurring payment plan. I may withdraw my authorization for future charges at any time by notifying Options Center. Withdrawal does not apply to services, products, purchases, cancellation charges, or other amounts already incurred or owed.

Appointments and Cancellations:

10. Consultation sessions are scheduled for approximately 50 minutes.
11. If I am late for a scheduled appointment, the consultation will still end at the originally scheduled time.
12. If I cancel with less than 48 hours' notice and do not reschedule the appointment, or if I miss the appointment without notice, I understand that I am responsible for the full appointment fee.

Communication:

13. Options Center may communicate with me by email or text regarding appointments, reports, newsletters, and other information related to services offered by Options Center. I understand that email and text communication may not be completely secure and I accept the use of email and text for communication related to my services.
14. I understand that email will be used for most correspondence related to my consultations, including scheduling, test information, reports, and follow-up communication.
15. I give Options Center permission to use my email address and mobile phone number for these purposes.

Laboratory and Functional Test Reports:

16. Laboratory and functional test reports may be provided before the consultation appointment. Because these reports require professional interpretation, clients are expected to review the results during a consultation session with Helen K. Cox, RN, BSN, LDN.

Functional Test Kit Policy:

17. Functional test kits (saliva, urine, or stool tests) should be completed and submitted to the laboratory within six months of purchase.
18. If a test kit is not used, it may be returned to Options Center within six months for credit if the kit is intact and includes the signed instruction sheet. Test kits returned after six months are not eligible for credit.

Client Acknowledgment:

19. I confirm that I have read and understand the statements and policies of Options Center for Health & Education, Inc. I voluntarily choose to receive consultation services and agree to the policies described above.

Client Information *Please print the following:*

Name: _____ Mobile/Cell Phone: _____

Address: _____ Home phone: _____

City _____ State _____ Zip code _____ Birth Date: _____

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 _____ QBO _____ Sales Contact _____ Coupon _____ Helen Contact _____ FullSript excel list
_____ Full Slate _____ Health Handbook Part 1 Word/Binders/Common documents/Client Statement.doc 10/1/2026 9:06 AM