The Medical Healing Center
225 Office Plaza Drive
Tallahassee, FL. 32301

Missed Appointment Consent Form for SCIO/QXCI

We are limited to how many SCIO/QXCI we can schedule in a day due to the length of the appointment. Please be advised that if you need to cancel a SCIO/QXCI appointment it is very important that we receive at least 24 hours notice so that we may call someone that is waiting for an appointment and fill that spot.

I understand that if it is impossible to keep my appointment,
I will notify your office within 24 hours prior to my appointment.
I understand that failure to attend my scheduled appointment, or failure to call within 24 hours will result in a $50.00 charge for the missed appointment (not billable to insurance).

_____ _____

Patient Signature Date

Evoked Potential Biofeedback Stress Response Testing Wellness Evaluation Authorization

Evoked potential biofeedback stress testing provides an opportunity to measure electrical responses of the body. Biofeedback evaluation of energy flow helps identify various stressors that might impede the electrical process. The evaluation may include recommendations for natural remedies, stress reduction methods and/or nutritional changes designed to balance and enhance overall wellness. These recommendations are not cures for any known diseases, nor have they been proven clinically to eliminate any specific disease process. The biofeedback evaluation is not a method of diagnosing, nor are the suggested remedies designed to replace any of the medications or treatments currently being provided or recommended by a primary care practitioner.

1. I fully understand that the attending consultant is not an allopathic doctor (MD) and does not pretend to be, but is a wellness practitioner providing services that are not allopathic, but that are within the parameters of a natural health and wellness philosophy.

2. I fully understand that the attending consultant does not offer allopathic drugs, surgery, chemical stimulants or radiation therapy but is providing information and natural products to restore natural balance and optimum conditions for health and wellness based on the scope of his/her practice.

3. I fully understand that the consultant is not diagnosing or treating any illness or disease, but is only measuring the biofeedback balance and overall stress responses of the body, and that these services may not be generally accepted and/or recommended by allopathic physicians or other health professionals.

4. I fully understand that the attending consultant is not encouraging me or terminate or modify any previous or ongoing therapies under the direction of any licensed practitioner, and that the attending consulting can/will not dissuade me from seeking allopathic attention, recommendations or modes of therapy from a licensed practitioner.

5. I presently seek consultation, advice, opinions and/or program, test, evaluations and/or products within the scope of attending consultants wellness practice based upon the principles of biofeedback health and have solicited the attending consultant's services in good faith, exerting my free will and following the dictates of my own conscience which allows me to select what I understand is most beneficial to my health.

6. I take full legal and total responsibility for any minor or incompetent accompanying me.

7. I authorize the attending consultant to provide their services to me on my behalf, and hereby release them from all claims and potential claims arising from my actions or failure to act upon their advice.

8. I fully understand that once the Biofeedback session has been performed that there will be no refunds for the service unless it is because of overpayment.

9. I give full faith that I have read and understand this document entirely, that I have received a verbal explanation of the same from the attending consultant; and that he/she has answered satisfactorily all of my questions regarding this form.

10. I am willing to declare all of the above statements by request of the attending consultant.

I hereby consent to and authorize the above described evaluation and consultation:

_____ _____

Client Signature Date

_____

Parent or Guardian Signature if Under 18

Demographics Questionnaire

Name at Birth: _____
First Middle Last

Current Name: _____
First Middle Last

Address: _____

_____
City Town/State Post/Zip Code

Telephone: _____ _____
Fax #

Email Address: _____

Place of Birth: _____ _____
Town Country

Date of Birth: _____ Time of Birth: _____

SOC Index: Suppression & Obstruction to Cure

Number of Organs Removed Two of 1 Kind=1 (Includes Adult Teeth)	Personal Stress 0-10 10 Being the Highest
Number of Pharmaceutical drugs Used currently	Number of Sugar type products daily Including Soft Drinks, ice cream etc.
Amount of Times you Smoke Daily (Number of cigarettes, cigars etc.)	Number of Exercise sessions per week 20 minutes or more – not work-based
Number of Steroid Type drugs used In the last year	Number of Alcoholic drinks daily On average
Number of Amalgam and/or Metal Fillings Currently, or present during the last year	Number of cups of coffee, tea Or any caffeine products daily
Number of street drugs used in the last month	Number of Extreme Toxic Exposures this year Including radiation, insecticide, chemicals, dental xrays, mammograms, MRI's, CT Scans, Ultrasounds
Number of all known allergies Food, airborne, and medicine	Number of major injuries past and present, including Emotional and all Traumas
Number of unsolved mental factors	Number of major infections past and present
Responsible for your body/disease (0=minimum /10=maximum	Number of glasses of Water or Natural Fruit Juices per day
Amount of Fat in diet, as percentage, including processed foods 20% Vegetarian, 30%Meat Eater, 40% Junk food eater	How many kilos overweight?
Are you pregnant?	Do you wear a pacemaker?