Bonnie Heidbrak
RPh. MBA. RMT. CCH. RSHom (NA)
PO Box 1205
Ridgway, CO 81432-1205
970-626-9828
Bonnie@IntrinsicVitality.com
www.IntrinsicVitality.com

DISCLOSURE STATEMENT AS REQUIRED UNDER COLORADO NATURAL HEALTH CONSUMER PROTECTION ACT

Complementary and Alternative Health Care Practitioners in Colorado are required under the Colorado Natural Health Consumer Protection Act to disclose the follow information:

I am not licensed, certified or registered by the State of Colorado as a health care professional, nor am I subject to licensure, certification or registration by the State of Colorado.

The nature of the services that I provide are homeopathic health care.

I have been in practice since 2003. I am a graduate of the Colorado School of Homeopathy (now known as Homeopathy School International) in Boulder, Colorado. I was credentialed as CHom from this school. I also completed post graduate studies with Dynamis School of Advanced Homeopathic Studies. I am Nationally Certified by the Council for Homeopathic Certification (CCH) and the North American Society of Homeopaths (RSHom, NA). These credentials require a minimum of 20 hours of advanced continuing education units (CEU's) each calendar year.

I am not covered by liability insurance application to any injury caused by an act or omission in my practice.

I recommended that you retain the service of a primary care physician, obstetrician, gynecologist, oncologist, cardiologist, pediatrician or other board certified physician or other licensed provider for appropriate medical evaluations, diagnoses and treatment. Any decisions about the medical treatment of disease or the changing of medical prescriptions will be made solely between you and your physician or other provider who made the prescription. If you know or suspect that you have a condition that may warrant the care of a licensed medical professional, you should seek medical as soon as possible.

I am required to recommend that you should discuss any recommendations that I make with your primary physician, obstetrician, gynecologist, oncologist, cardiologist, pediatrician or other board certified physician.

Homeopathy is considered to be a holistic, natural system of care and is not intended to be a substitute for allopathic medicine namely, conventional western medicine. The services and information provided should not be construed by you, the client, to be a medical or other diagnosis or treatment of any disease or injury.

By signing this Disclosure/Disclaimer, you, the undersigned, are acknowledging the following:

I, _____, am a competent adult over the age of 18.

I have read and understand the disclosure above about homeopathic treatment offered by Bonnie Heidbrak and her training and education. I voluntarily consent to the use of the homeopathic service for myself.

I have read and understood the information in this handout and understand that Bonnie Heidbrak is not a licensed medical doctor, physician or health care provider. She does not diagnose, treat or prescribe for any disease, illness, syndrome or condition.

Bonnie Heidbrak is helping me by seeking to find a Homeopathic remedy which improves my general well-being and increases my general energy and constitutional vitality.

I understand that all information disclosed is confidential and may not be revealed to anyone without written permission except where disclosure is required by law. Disclosure may be required in the following circumstances: a reasonable suspicion of child or elder abuse; a reasonable suspicion that a client presents a danger to him or herself or to others.

I authorize discussion of my case notes with other professional homeopaths if assistance in remedy selection and/or symptom analysis be required for myself or my best interests be served by such a consultation. In doing so, my right to privacy will be protected by withholding my name and all other identifying information.

I have read and, understood and acknowledge the above disclosure and disclaimer in its entirety. I agree that I have received this information as required by the Colorado Natural Health Consumer Act and have received a copy of this notice.

_____ _____

Name of Client Date of Birth

_____ _____

Signature of Client Date

For Parents or Guardian of Clients who are ages 8-18

If the Client is between the ages of 8 to 18, the parent or guardian should sign and list below their signing authority (parent, guardian, or other party)

The services are for my child or ward (ages 2 to 18) and I represent that I have authority to make health care decisions for my child/ward, and in my judgment it is in the child's or ward's best interest to receive homeopathic care, and that if I have any concerns or questions whatsoever about my child's health, I will take my child/ward to a competent physician in a timely manner.

I give consent for Bonnie Heidbrak to treat my child.

I acknowledge that understand that Bonnie Heidbrak is not a licensed medical doctor, physician or health care provider. She does not diagnose, treat or prescribe for any disease, illness, syndrome or condition.

I acknowledge that Bonnie Heidbrak recommends that my child or ward have a relationship with a licensed pediatric health care provider.

Name of Child/Ward (Print) Date of Birth

Name of Parent or Guardian (printed)

Signature of Parent or Guardian Date

Are you a parent or guardian or ?

For Parents or Guardian of Clients who are ages 2-7

If the Client is between the ages of 2 to 7, the parent or guardian should sign and list below their signing authority (parent, guardian, or other party)

The services are for my child or ward (ages 2 to 18) and I represent that I have authority to make health care decisions for my child/ward, and in my judgment it is in the child's or ward's best interest to receive homeopathic care, and that if I have any concerns or questions whatsoever about my child's health, I will take my child/ward to a competent physician in a timely manner.

I give consent for Bonnie Heidbrak to treat my child.

I acknowledge that understand that Bonnie Heidbrak is not a licensed medical doctor, physician or health care provider. She does not diagnose, treat or prescribe for any disease, illness, syndrome or condition.

I acknowledge that Bonnie Heidbrak recommends that my child or ward have a relationship with a licensed pediatric health care provider.

Does your child have a relationship with a license pediatric health care provider?
Yes____ No___

If yes, what is the Name and Address and Phone number?

_____

_____

Also if YES, do you give permission for us to attempt to develop and maintain a collaborative relationship with Child's license pediatric health care provider? If you answer YES we will call, write or email or pediatrician. If you answer NO, we will not.
Yes____ No _____

_____
Name of Child/Ward (Print) Date of Birth

_____
Name of Parent or Guardian (printed)

_____
Signature of Parent or Guardian Date

Are you a parent or guardian or ? _____