



Bonnie Heidbrak RPh, MBA, RMT, CCH, RSHom (NA)  
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## Client Statement of Consent

**Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

Bonnie Heidbrak has been in practice since 2003. She is a graduate of the Colorado School of Homeopathy in Boulder, Colorado and the Dynamis School of Homeopathy in England. She is Nationally Certified by the Council for Homeopathic Certification (CCH) and the North American Society of Homeopaths (RsHom(NA)).

Homeopathy views health and illness in a holistic manner. A homeopath takes into consideration the client's mental/emotional situation and general well-being as well as specific physical symptoms. Homeopathy works by stimulating the body's own capacity to heal. The objective of homeopathy is to help stimulate this innate healing potential. The goal in the homeopathic interview is to explore your health concerns and to suggest the most likely homeopathic remedy to fit your symptoms picture. A minor aggravation or worsening of symptoms may occur as a part of the general healing process.

It is recommended that you retain the service of a primary care physician or other licensed provider for appropriate medical evaluations, diagnoses and treatment. Any decisions about the 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.

Homeopathy is compatible with and does not interfere with most orthodox, complementary or alternative treatments, and one may, depending on circumstances, choose to utilize the benefits of more than one discipline.

Homeopathy is a therapeutic treatment. For it to be effective, follow-up appointments are suggested every 3-6 weeks for the first 6-9 months, and possibly longer depending on the natures of the illness for which the clients is seeking treatment.

I, \_\_\_\_\_, am a competent adult over the age of 18 years and I do hereby voluntarily choose and consent to homeopathic care for myself, my child (ren) or ward(s), \_\_\_\_\_ . 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 services, for myself, child (ren), or ward(s), after having fully informed myself about homeopathy.

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. She is helping me to increase my general energy and constitutional vitality.

I also understand that Bonnie Heidbrak does not bill insurance companies and that it is my responsibility to pay in cash or check in full at the time of service. I further understand that I must give 24 hours notice to cancel an appointment or may be held financially responsible for the appointment.

If the services are for my child or ward, 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 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 understand that homeopathy is therapeutic and for my treatment to be effective, it is my responsibility to schedule follow-up appointments every 3-6 weeks for the first 6-9 months of treatment. When follow-up appointments are needed less frequently Bonnie Heidbrak will tell me how often I need follow-up appointments for optimal treatment.

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 child 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 understand that everything in this Information and Consent that refers to me, or the client, also refers to my child or ward, as appropriate.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name (Print)

\_\_\_\_\_  
Name of Child/Ward (Print)