New Patient Information

Name ____

Address ____

City ____________________________________ State ________ Zip _____________

Daytime Telephone # ____

Nighttime Telephone # ____

Cell Phone # ____

Email Address ____

Date of Birth ______________________________ Age __________________________

Referred By ____

Family Doctor ____

Other Doctor ____

Marital Status : M S D W

Spouse's Name (or Parents' Names) ____

In case of emergency contact ____

Relationship ____

Telephone # ____

* This is a non-covered service, not usually billable to your insurance.
Payment is expected at time of service.

We accept cash, check or credit card. Phone consultations maybe paid through Pay Pal.

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Information and Consent Form

The **Consolidated Energy Wellness System** is a treatment protocol involving several phases: bioenergetic testing; specific organ and glandular detoxification and drainage through the use of homeopathic remedies; digestive and systemic therapy; and energetic communication with the energetic system to restore balance. This last aspect of the

Consolidated Energy Wellness System can be used to determine the disease causing agent whether it be a pathogen, metal toxicity, a hormonal imbalance, an emotional trauma, inflammation, or a sensitivity to foods, medicines, pollens, dust, mold, animals, chemicals, or almost anything else. Then by utilizing an acupressure technique that is a very simple, safe, non-intrusive, and very effective, we can work toward permanently eliminating the agent or the energy blockages created by the agent and any reaction or sensitivity to that agent.
After a treatment some people can experience what is know as a healing crisis. This will be discussed with you during the initial evaluation. Usually these symptoms are relatively mild and will only last between 1-3 days. However, if you find that these symptoms are more severe or are lasting longer than the 1-3 days, please contact our office to discuss how to proceed.

It is Your Responsibility To:

1. Follow the instructions that are given to you at the end of each treatment session, so that you will know what to expect during clearing phase.
2. Contact me as soon as possible if you are experiencing severe symptoms following the treatment.
3. Inform me of anything to which you have ever had a strong or severe reaction, such as hives, itchy or swollen eyes, asthma, difficulty breathing, lips, tongue, or throat swelling, dizziness, fainting or shock.
4. Tell me immediately if you experience any throat or chest tightening or difficulty breathing during the treatment.
5. If you have an epinephrine pen which your doctor has instructed you to use for severe allergic reactions, bring it with you to each treatment.
6. Return to be rechecked as soon after the number of days as to which you were told the treatment would be completed.
7. **Seek conventional medical or emergency help if you are experience very severe or life threatening symptoms.**
8. If you have accepted a recommended homeopathic remedy, enzyme, or other supplement, inform me as soon as possible as to any adverse effects after taking them.

There are many patients who come into this office who have allergies and many of them get sick from environmental fumes. **Therefore, NO perfume, cologne, scented hair sprays or strongly scented body oils or lotions are allowed in this office.** It is also helpful to keep the wearing of jewelry to a minimum during the treatments.

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Consent

The undersigned acknowledges that the techniques and treatments being utilized with the **Consolidated Energy Wellness System** are not generally recognized by the medical community and that there is no license requirement in the Commonwealth of South Carolina for these procedures.
Overall, the **Consolidated Energy Wellness System** treatments are very safe, and most people experience mild to no symptoms during the clearing phase. If you are having a problem which is not severe, try to ride it out. It is probably just a function of the clearing and should resolve after 1-3 days. If it does not resolve, call the office to discuss how to proceed.
If you have a severe or life threatening reaction, DO NOT HESITATE TO CALL YOUR DOCTOR OR USE EMERGENCY MEDICAL CARE. Call my office to notify me of your condition and arrange to be re-tested as soon as possible.
Because we cannot anticipate your reaction to a treatment or control your exposure or reaction to the allergen during the clearing phase, we cannot assume responsibility for any reaction you might have during or after a treatment.
I, the undersigned, hereby release Cheryl Wisener from any claim whatsoever, and hold her free and harmless from any claim, suit for damages or complications which may result from the treatments I receive. I have read this form carefully and understand my responsibilities in this process. I have felt free to ask any questions, and my questions have been answered satisfactorily.
I authorize Cheryl Wisener to call 911 Emergency if my condition is ever life-threatening, and administer epinephrine if she is instructed to do so by the Emergency Medical Technicians before they arrive.

Date ____________________

____
Patient or Guardian Signature

____
Client Printed Name

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PROVIDERS DECLARATION OF NINTH AMENDMENT RIGHTS

ARTICLE IX, U.S. CONSTITUTION
"The enumeration in the Constitution of certain rights, shall not be construed to deny or disparage others retained by the People."
I, Cheryl Wisener, hereby declare and retain the following natural and God-given rights under Article Amendment IX of the Constitution of the United States of America:
1) The right to obtain an education from any institution or private school, including those whose views are different from conventional practice of healing,
2) The right to perform evaluations and set up programs for the purpose of enhancing the health of my clients without being required to obtain a license from any government authority, and to do so in a manner consistent with my training and background. My training and background include successfully completing the Advanced Course of studies in Homoeopathic Medicine and meeting the required standards in the final examination to qualify for the award of Diploma of The Institute of Homoeopathy and also completing 100+ hours of advanced study in the BioSET protocol under the instruction of Dr. Ellen Cutler to receive certification as a BioSET Practitioner.
3) The right to provide products, regimens, modalities and services to anyone for any benefit or purpose providing:
a. I shall not provide any service that I am not qualified to provide based on my experience and education;
b. I shall make no false representations about my education and training experience;
c. I shall make no intentionally exaggerated, false or misleading claims for the health products and services that I provide;
d. I shall inform any one to whom I provide products and services when the protocol or regiment is experimental;
e. I shall avoid claiming that someone was "cured" of an illness unless the disease remains in remission for five years or longer;
f. All persons will be advised in a "Client Request and Authorization Form" to seek a second evaluation from a medical doctor, unless they have already done so.
4) I retain the right to provide customer references upon request.
5) I retain the right to use testimonials.
6) I retain the right to provide information on the intended purposes and benefits of my products and services. The health and well-being of my clients shall by my sole concern. All clients will be given a copy of this Health Care Provider's Notice at the time of initial consultation.
7) All rights retained herein are declared retroactive to the date of my 18th birthday.
The enumeration, in this declaration of these rights shall not be construed to deny or disparage others retained by me, or my right to amend this declaration at any time. These rights, which are assertive for reasonable and good cause, are declared to be retained by the people under the Ninth Amendment to the Constitution, all state and federal laws to the contrary notwithstanding. In any litigation brought by any party objecting to the rights declared herein, a jury, representing the people, shall have the right to modify, nullify, or expand upon the Ninth Amendment rights claimed in this document.
Notice is hereby given to any person(s) who, acting under the color of law. intentionally interferes with the free exercise of the rights retained by me under the Ninth Amendment, as enumerated in this declaration, that they may be in violation of my civil and constitutional rights, Title 42, U.S.C. 1983 et seq. and Title 18, Section 241.

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CLIENT REQUEST AND AUTHORIZATION

I, the undersigned, request that Cheryl Wisener perform an evaluation and set up a program for the purpose of enhancing my health.

I understand that Cheryl Wisener has successfully completed the Advanced Course of studies in Homoeopathic Medicine and has met the required standards in the final examination to qualify for the award of the Diploma of The Institute of Homoeopathy and has also completed 100+ hours of advanced study in the BioSET protocol under the instruction of Dr. Ellen Cutler to receive certification as a BioSET Practitioner. I understand that Homoeopathy and the BioSET protocol are not recognized by the conventional practice of healing and are not intended as a substitute for regular medical care.

ARTICLE IX, U.S. CONSTITUTION

"The enumeration in the Constitution, of certain rights, shall not be construed to
deny or disparage others retained by the People."

Under the Ninth Amendment to the Constitution of the United States of America, I retain the right to freedom of choice in health care. This includes the right to choose my diet, and to obtain, purchase and use any therapy, regimen, modality, remedy or product recommended by the therapist, doctor, or any practitioner of my choice.

The enumeration in this declaration of these rights shall not be construed to deny or disparage other rights retained by me, or my right to amend this declaration at any time.

CONSTRUCTIVE NOTICE

Notice is hereby given to any person who receives a copy of this Declaration and who, acting under the color of law, intentionally interferes with the free exercise of the rights retained by me under the Ninth Amendment, as enumerated in this declaration, that they may be in violation of my civil and constitutional rights, Title 42, U.S.C. 1983 et seq. and Title 18, Section 241.

Date ____________________

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Patient or Guardian Signature

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Client Printed Name

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Ionic Detoxification Footbath Consent

The Undersigned acknowledges that the Ionic Detoxification Footbath Technique being utilized is not generally recognized by the medical community and that there is no license requirement in the state of South Carolina for this procedure.

Overall, this treatment is very safe and most people experience mild to no symptoms following the treatment. If you are having a problem which is not severe, try to ride it out. It is probably just a function of detoxification and should resolve itself within a few days. If it does not resolve, call the office to schedule another appointment within the next few days.

I, the undersigned do not have a pacemaker, an imbedded defibulator or any other electrical device that the electric Ionic detoxification Footbath could interfere with. I also have discussed any other concerns that I have with my practitioner prior to utilizing the Ionic Detoxification Footbath.

If you have a severe or life threatening reaction, DO NOT HESITATE TO CALL YOUR DOCTOR OR USE EMERGENCY MEDICAL CARE.

Call my office to notify me of your condition as soon as possible.

Because we cannot anticipate your reaction to the detoxification, we cannot assume responsibility for any reaction you might have during or after the detoxification footbath.

I, the undersigned hereby release Rickey and/or Cheryl Wisener for any claim whatsoever, and hold them free and harmless of any claim, suit for damages or complications which may result from the treatments I receive. I have read this form carefully and understand my responsibilities in this process. I have felt free to ask any questions, and my questions have been answered satisfactorily.

I authorize Rickey and/or Cheryl Wisener to call 911 Emergency if my condition is ever life-threatening.

Date ___________________________

____
Patient or Guardian Signature

____
Client Printed Name

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