



**STATEMENT OF UNDERSTANDING**

I understand that Jennifer Carlson is an Ayurvedic Consultant and Educator who provides me with information on the Ayurvedic approach to health care, which may affect my diet and health in a positive way. I understand that Jennifer is not a medical doctor or licensed medical practitioner, has not presented herself such, and does not seek to diagnose, treat or prescribe for disease, disorder or other pathological conditions.

I agree that I am interested in enhancing my own abilities to heal and establish health in mind and body, and this is the reason I have sought these Ayurvedic consulting services. I agree that I may consult a licensed physician for any concern, at any time, about any disease or pathology, which now exists or arises at any time during my professional relationship with Jennifer.

Furthermore, I understand that Jennifer encourages regular medical checkups from a licensed medical professional of my choice, and that any medication that I am now taking upon my licensed physician's advice, or will take in the future, is taken strictly according to my licensed physician's directions. Furthermore that only a licensed physician of my choice can advise on medication dosages or the discontinuance or resumption of such medication.

I understand and agree that I am ultimately responsible for the cost of any and all professional services rendered.

Minor children are required to have a parent or legal guardian present at the time of their appointment or no service will be provided and the appointment will be rescheduled. In the case of divorced or separated parents, the parent who brings the child into the office is responsible for any charges.

I authorize Whole Life Health Care, P.A., and its physicians, health care practitioners, employees and the subcontractors in collaboration with Whole Life Health Care, P.A., to have access to my medical records for the purpose of medical treatment/services within the Whole Life Health Care, P.A. facility.

24 hour notice is requested when canceling appointments.

*My signature below acknowledges the above statements as fully read and understood.*

Client's signature \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian signature \_\_\_\_\_ Date: \_\_\_\_\_

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