

Luna Herb Co.
Client Full Disclosure Form

I acknowledge and confirm that:

- I am of legal age and I am requesting a consultation with Kristine Brown, a member of the American Herbalists Guild participating in the mentorship program to enhance her skills toward professional registration with the American Herbalist's Guild.
- This consultation is not to diagnose or treat disease, but for education and support of wellness.
- I understand that this consultation is not intended to replace medical care and that I will seek medical treatment from a licensed health care provider if required.
- I understand that botanical and nutritional supplements may be contraindicated with certain health conditions. For this reason, I confirm that I have had a general physical from a Medical Doctor within the last 12 months, or have chosen not to, and have disclosed any diagnoses on the intake form.
- I understand that botanicals and nutritional supplements can interact with medications. For this reason, I have disclosed all medication on the intake form.
- I understand that it is my constitutional right to decide how I wish to care for my health. Kristine has not suggested that I cease any current medical care or therapies. I have sought Kristine's advice and I recognize that I am free to act upon her recommendations as I see fit, and, as such, release her and her mentor of all responsibility for my actions and any consequences thereof, both now and in the future.
- I understand that I am under no obligation to follow any of the recommendations made.
- I understand that herbal medicine is not regulated or approved by the Federal Drug Administration.
- I understand that no guarantees are made or implied regarding results from botanical or nutritional supplements or natural health methods, and that achieving wellness requires my commitment to my own good health, whether through diet, exercise, or lifestyle changes.
- I understand that the information that I share with Kristine is shared in confidence.
- I am here on this and subsequent visits solely on my own behalf and not as an agent of federal, state or local government agencies for purposes of investigation or entrapment.
- I understand that payment is due at the time that consultation services are rendered.

Name: _____

Signature: _____ Date: _____

Due to HIPPA privacy regulations, your information will be held confidential and not shared with anyone.

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INFORMED CONSENT

As a part of her training, Kristine Brown will review consultation cases with her mentor, who is a professional clinical herbalist. Each case history will be presented anonymously to the mentor and all identifying information (such as client name and address) will remain completely confidential.

In order to prove that she has met requirements for clinical experience, Kristine Brown will keep a separate list of client names and contact information, along with dates when she/he met with each client for consultation or follow-up appointments. This record will be submitted to the American Herbalists Guild (AHG) as part of her professional application. There will be no information concerning the nature or details of the wellness consultation included in this record. I understand that in order to verify that this consultation did take place, a representative of the Admissions Committee of the AHG may contact me. Should this verification be required, the AHG representative will not have any information about the consultation nor will they ask any questions about the nature of the consultation.

By my signature below, I indicate my willingness for Kristine Brown to:

- Share my case information (without my name or any contact information) with her mentor.
- Share my name, contact information, and date(s) of consultations (without any details about the nature of the consultation) with the American Herbalists Guild.

Name _____

Signature _____ Date _____