

Application for Services

Santosha Ayurveda LLC

This session will provide an educational Ayurvedic consultation in order to:

- Determine my mind body constitution
- Identify and assess any imbalances that may exist
- Provide information and guidance relevant to helping me nourish, stimulate or balance vital energy
- Develop a plan with me for lifestyle changes that may improve my general health and wellness

I agree to:

- Study the information provided
- Participate in the development of my health and wellness plan
- Notify my primary care provider, in under their care, of my intention to begin a new health and wellness plan
- Discontinue any or all of the health and wellness plan elements if any discomfort occurs and notify my consultant and primary care provider if any.

Fees:

- The fee for the consultation is:
- Fees are for the consultation and information only and do not include any other services or products
- There would be additional charges and fees for any additional services or products
- Fees are due at the time the services are rendered
- Payment may be made by cash, check, Visa or MasterCard
- The Santosha Ayurveda LLC does not accept health insurance

Confidentiality:

- Confidentiality is strictly enforced
- At no time will your file be taken from or information contained in your file disclosed for any reason to anyone outside the consultant at Santosha Ayurveda LLC
- Information contained in your client file may at times be used as a case study in one or more classes in such a way that you cannot be identified

Please return the following documents before the consultation

1. Health Information and History (pages 2,3& 4)
2. Application for Services (page 1)

The purpose of this consultation is to provide an Ayurvedic learning opportunity for the client and should not be considered as medical advice.

I have read all the information contained in this packet, answered all questions and have completed the medical information and history.

I understand that this is an educational Ayurvedic consultation for the purpose of helping me to improve my own health and wellness. I understand this does not include medical diagnosis or medical treatment, and is not a substitute for medical care. It is not an agreement for on-going care. This consultation is meant to compliment and not replace your regular visits to your Primary care Practitioner or traditional Western Doctor.

_____ Date _____
(Client/Guardian Signature)

Client Name:	Address:
Daytime Phone:	City, State, Zip