CLIENT ACKNOWLEDGEMENT FORM

I hereby attest to the following:

1. I am here, on this and any subsequent visit, solely on my own behalf.
2. I fully understand that BIE practitioners, Nutritionists, Herbalists, Acupuncturist and Homeopaths, are not medical doctors and I am not here for medicinal diagnostic or treatment procedures. I understand that results and any benefits of the services may vary.
3. The services performed by Kim Sebben, are at all times restricted to consultation on the subject of nutritional matters or the BIE modality, and does not involve the use of medical tests such as, scratch tests, needles, blood or urine tests to verify the client's medical condition, disease, sensitivities or intolerances to foods or environmental substances. All testing is done for experimental or educational purposes only. The GSR-120 unit is not intended to be used to diagnose, cure, prognosticate, treatment or prescribing of remedies for the treatment of disease or any act which will constitute the practice of medicine in this country in which a medical license is required.
4. All suggestions regarding herbs or nutritional matters are based on historical and traditional use.
5. The BIE modality and the GSR-120 does not and is not intended to support or provide claims to diagnose, treat, or cure anaphylactic life threatening or non-life threatening allergies, medical condition or disease. The client should not for any reason, ingest or expose himself/herself to any substance that he/she has previously been diagnosed as allergic or anaphylactic by a qualified physician/allergist, or is aware of any severe allergy to a substance unless he/she has first been given consent by a qualified physician/allergist.
6. Program compliance is required for guaranteed results.
7. The GSR-120 unit is used to direct energy directly onto various acupuncture points on the body to help create homeostasis.
8. I have a pace maker YES ☐ NO ☐
9. I am pregnant YES ☐ NO ☐
10. The decision to follow any recommendations made rests solely with the undersigned.

PLEASE PRINT

Client Name:_____

Address:_____

City:_____ Prov:_____ Postal Code:_____

Daytime Phone:_____ Evening Phone:_____

Date of Birth:_____

Signed:_____ Date:_____

(Parent/Guardian if under age 18)

Kim Sebben, RHN, R.BIE
Sunrise Health Services, 413 Hibernia Street, Stratford, ON N5A 5W2
519.271.0763 www.sunrisehealthservices.ca

E-mail and Text Communication Consent Form

I hereby acknowledge that I have requested the opportunity to communicate by e-mail and/or text communication. I understand that in this manner that I am exposing myself to certain risks. These risks include:

- The privacy and security of e-mail and/or text communication cannot be guaranteed.
- Employers and online services may have a legal right to inspect and retain e-mails and/or texts that pass through their systems.
- It is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the e-mail and/or text once it has been sent.
- E-mails and/or texts can introduce viruses into the operating system, and potentially damage or disrupt the computer and/or phone.
- Email and/or text are indelible. Even after the sender and recipient have deleted their copies of the e-mail and/or text, back-up copies may exist on a computer or in cyber space.
- If the patient's email and/or text requires or invites a response from the Sunrise Health Team, and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the Sunrise Health Team received the email and/or text and when they will respond.
- The patient is responsible for informing the Sunrise Health Team of any types of information the patient does not want sent by e-mail and/or text.

The Sunrise Health Team will use reasonable means to protect the security and confidentiality of e-mail and/or text information sent and received; however, because of the risks just outlined, the Sunrise Health Team cannot guarantee the security and confidentiality of e-mail and/or text communication, and will not be liable for improper disclosure of confidential information that is not the direct result of intentional misconduct by the Sunrise Health Team.

Although the Sunrise Health Services Team will endeavor to read and respond promptly to an e-mail from a patient, we cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Accordingly, patients should not use e-mail and/or text for medical emergencies or other time-sensitive matters. E-mail and/or text communication is not an appropriate substitute for clinical examinations. The Sunrise Health Team are not able to diagnose or give additional treatment advice via e-mail and/or text.

PATIENT AKCNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication by e-mail and/or text between the Sunrise Health Team and me and I consent to communication by e-mail and/or text in spite of these risks.

Patient Name_____ Date _____

Patient E-mail _____

Patient Cell Phone_____ Patient Home Phone_____

Preferred method of communication: ☐ text ☐ email ☐ home phone

Signature _____
(Patient or Guardian signature)

food & activity report

NAME: WEEK NO:

Please take time to complete the following survey carefully and accurately. List in detail the quantity and the exact nature of all foods and beverages consumed (ie. frozen, canned, etc.). Please mention if the foods were raw or cooked. Be sure to list any condiments used (ie. mayonnaise, ketchup, margarine, relish, etc.).

sunrise
HEALTH SERVICES

MEAL	DAY ONE	DAY TWO	DAY THREE	DAY FOUR
Morning meal & time				
Snack				
Noon meal & time				
Snack				
Evening Meal & time				
Snack				
Condiments (salt, sugar, herbs, spices, etc.)				
Fats / Oils used				
Water (cups per day)				
Other beverages				
Type of exercise				

Continued on reverse ›