



Client Responsibility Agreement

Please read disclosure below fully before signing consent

I, _____, agree to the following responsibilities as a client of
(Patient's name here)

Paradigm Health Group ("Paradigm"):

- 1) I understand that I am responsible for all costs associated with my care at Paradigm Health Group. This includes, but is not limited to: consultations, treatments, evaluations & labs, supplementation, professional letters/correspondences, and courier or shipping costs. I also know that I will be duly informed by a member of Paradigm Health Group of any costs prior to my incurring them. All costs associated with my care (mentioned above) are due on the day services are rendered.
- 2) I am responsible for making my own appointments and notifying Paradigm Health Group with sufficient notice should I be unable to attend a scheduled appointment. Appointments missed or rescheduled without sufficient notice carry a financial penalty
- 3) I understand that there is a **48** hour cancellation policy at Paradigm. Any missed appointments, or appointments cancelled within 48 hours, carry a financial penalty of \$50.00 – with the only exception being Intravenous (IV) Therapy Appointments; in which case, half the cost of the scheduled appointment will be billed. I am responsible for paying any fees before subsequent appointments can be booked.
- 4) I agree that should I be later than half the length of my appointment, I will likely need to reschedule my appointment. Though every attempt will be made to accommodate late clients, Paradigm is unable to make guarantees in this regard.
- 5) I understand that it is my responsibility to follow-up with my care provider at Paradigm via phone or in clinic consults should phone messages or email not be answered in a timely fashion. Inquiries regarding changes or continuation of my treatment plan require a follow up appointment.
- 6) I will familiarize myself with all instructions or guidance for testing or visits provided by Paradigm Health Group prior to the scheduled appointment.
- 7) Out of respect for the staff at Paradigm, I will ensure that my cell phone is turned off during my appointment times.
- 8) I understand that Paradigm is a "Scent-Free" environment, and will refrain from wearing toiletries and/or cosmetics that are scented (ex: cologne, perfume, aftershave etc...)

Dated this _____ day of _____, 20_____.

Patient/Guardian Signature

Witness Signature

Patient/Guardian Name (Please print)

Witness Name (Please print)

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