



Client Responsibility Agreement

I, _____, agree to the following
(*patient name*)
responsibilities as a client of Paradigm Health Group ("Paradigm"):

1. I am responsible for making my own appointments and notifying Paradigm with sufficient notice (one business day (24 hours) prior to my appointment) should I be unable to attend a scheduled appointment. Appointments missed or rescheduled without sufficient notice carry a financial penalty.
2. I understand 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.
3. I realize that I am responsible for all costs associated with my care at Paradigm. This includes, but is not limited to, consultations, treatments, evaluations & labs, supplementation, professional letters/correspondences and courier & shipping costs. I also know that I will be duly informed by a member of Paradigm of any cost prior to my incurring them.
4. I understand that it is my responsibility to follow-up with my care provider at Paradigm via phone or clinic consults should phone messages or email not be answered in a timely fashion. Inquiries regarding changes or continuation of my treatment plan will require a follow-up appointment.
5. I will familiarize myself with all instructions or guidance for testing (e.g. BTA/FSA) or visits (e.g. temperature readings, diet diary) provided by Paradigm prior to the scheduled appointment.
6. Out of respect for the healing environment at Paradigm I will ensure that my cell phone is turned off during my appointment times and refrain from wearing any toiletries and cosmetics that are scented.

Signature

Date

Name (please print)