**** 3050 W 151St Ct.

Suite 100

Broomfield, CO 80023

www.aboundinghope.life

(303) 494-3116 Office

**Client Information**

**Name** (First, Middle, Last) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Guardian Name** (If applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone** (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (W) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (C) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 (Street) (City) (State) (Zip Code)**

**Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Age \_\_\_\_\_\_\_ Sex \_\_\_\_\_**

**Email Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Name/Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Referring Person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Primary care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client Financial Agreement**

* Cancellation of appointments needs to be done at least **24 hours in advance,** otherwise we will need to charge a $50.00 no show fee.
* There is a $25.00 fee for all administrative/consultative letters requested on behalf of the client.
* A **1 week turn around** for completing requested forms or providing copies is kindly requested. If you require copies of any portion of your records a fee may be charged to offset administrative expenses.
* A **$40.00** fee will be charged for any returned checks.
* A minimum fee of **$25** will be charged to the client if this account should be sent out for collection.
* Should this account be referred to an attorney, a collection agency, or court, **I agree to pay all collection/attorney fees** that may be incurred by Kerry Sprague or any party associated with AHHO in connection therewith or any other fees or expenses incurred by Kerry Sprague or any party associated with Abounding Hope Health Options LLC in relation to this account. If my account is delinquent, I agree to pay interest on the full outstanding balance at the maximum rate allowed by law.
* **I understand that Abounding Hope Health Options LLC does not accept any form of health coverage and that I am fully responsible to pay the full charges of all services rendered at the time of the appointment.**
* A copy of this agreement may be used in place of the original.

**Signature of Client/Guardian ­­­­­­­­­­­­­­­**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**­­­­**

3050 W 151St Ct.

Suite 100

Broomfield, CO 80023

www.aboundinghope.life

(303) 494-3116 Office

**Permission to Discuss**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give Kerry Sprague of Abounding Hope Health Options LLC permission to discuss all necessary information with employees of Abounding Hope and the following information (as indicated):

\_\_\_\_\_\_\_\_\_\_\_\_ All of the following

\_\_\_\_\_\_\_\_\_\_\_\_ Evaluation Results

\_\_\_\_\_\_\_\_\_\_\_\_ Billing Information

\_\_\_\_\_\_\_\_\_\_\_\_ Nutritional Supplement (Sol) Information

\_\_\_\_\_\_\_\_\_\_\_\_ Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

With the following people:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client/Guardian Date

\*\*\*Note: This form must be filled out in order to ensure the confidentiality of our client’s records.

3050 W 151St Ct.

Suite 100

Broomfield, CO 80023

www.aboundinghope.life

(303) 494-3116 Office

**Notice of Non-Coverage**

**Attention: Kerry Sprague and Abounding Hope Health Options LLC do not participate with any health coverage provider.**

|  |  |
| --- | --- |
| **Services** | **Estimated Cost:** |
| Auricular Medicine Evaluation (AME) and Initial Consultation | $385.00 AME and initial consultation |
| AME/Follow-up (EVERY 8 WEEKS) | $125.00 Follow-up AME each visit |
| 6 months – 1 year of no follow-up appointments | $175 re-evaluation fee |
| Over 1 year of no follow-up appointments | $385.00 (considered new evaluation) |
| Liquid Nutritional Supplements/Sols (1 bottle lasts approximately 8 weeks) | $50.00 - $60.00 per bottle\*\*/This can range from $150-2000+ per appointment |
| Pellet Nutritional Supplements/Sols (for those who cannot have alcohol) | $55.00 - $65.00 per bottle\*\*/This can range from $150-2000+ per appointment |
| Evaluation of External (non-Abounding Hope) Products | $10 per item evaluated |

**\*\*For further explanation of fees and approximate total cost, please call us or visit our website at** [**https://www.aboundinghope.life/faq-s**](https://www.aboundinghope.life/faq-s) **and read the section on “What is the cost?” and “Sprays vs. Pellets.”**

**Please ask us any questions that you may have!**

**Signing below means that you have received this notice and understand the fees listed above.**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3050 W 151St Ct.

Suite 100

Broomfield, CO 80023

www.aboundinghope.life

(303) 494-3116 Office

**Consent for Auricular Medicine Evaluation and Sol Therapy**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the undersigned below request and agree to the holistic evaluation and treatment through alternative medicine approaches which may include auricular medicine and other complementary and alternative approaches as supplements to traditional medical treatment done by your primary care Physician(s). I understand that:

* There is a lack of sufficient scientific data to support the efficacy of these approaches.
* A consultation with your primary care Physician regarding any and all illnesses, health concerns, and/or symptoms being experienced is ***strongly*** recommended by Abounding Hope Health Options LLC (AHHO) prior to the alternative medicine evaluation.
* AHHO offers alternative therapy options that are nutritionally based which are intended to be both complementary and a supplement to your current medical practitioner(s) and NOT a replacement thereof.
* The initial fees do not include the cost of the nutritional supplements (Sols).
* I will be financially responsible for all services rendered and products received and/or ordered at the time of visit. \_\_\_\_\_\_\_\_\_\_\_\_\_\_Please Initial

I consent that I knowingly, intelligently, and voluntarily accept the risk of the treatment provided with due care. I also understand that it is best to combine these approaches with conventional medical treatment and have been recommended to do so by Abounding Hope Health Options LLC. If I choose to abandon traditional medical treatment exclusively in favor of the supplemental complementary alternative therapy approaches, I acknowledge that I do so against the advice of Kerry Sprague of Abounding Hope Health Options LLC and take full responsibility for this decision and the risks thereof.

I understand that I am to continue to monitor my condition through conventional medical treatment as well as the supplemental complementary alternative treatment. I will do so by consulting with both my primary care physician and Abounding Hope Health Options LLC. I consent that I have been advised by Kerry Sprague of Abounding Hope Health Options LLC not to eliminate or delay my conventional medical treatment without consulting with my primary care Physician.

I confirm that neither Kerry Sprague nor any of her staff have given me any guarantees or promises with respect to the outcome of the complementary and alternative treatment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client/Guardian Date

3050 W 151St Ct.

Suite 100

Broomfield, CO 80023

www.aboundinghope.life

(303) 494-3116 Office

**Consent for Electronic Receipt of Invoices**

Abounding Hope Health Options, LLC works mainly via electronic format for communication purposes, including the sending of invoices and receipts. As such, clients may or may not receive a paper invoice at the time of their appointment, but generally receive it subsequently via email. Clients can always request a paper copy prior to leaving the office, but understand this may cause a delay in the length of check out.

The following verbiage is included on every invoice, however as the invoice may not be received at the time of service, we ask you to review and acknowledge the following ahead of time:

* Nutritional supplements (Sols) are recommended to be taken without interruption for eight weeks or until your next scheduled follow-up appointment unless otherwise specified. Please carefully read the instructions provided separately to ensure the best possible results.
* In approximately 7-10 days you may experience an exacerbation of your symptoms. This is referred to as a “healing crisis” (sometimes referred to as herx). This is normal and expected, although it does not affect everyone. Few clients may experience strong reactions that may need adjustment of the protocol. You need to contact this office if you experience strong reactions to receive instructions necessary to minimize this response.
* Nutritional supplements (Sols) may contain alcohol or lactose. If you have allergies to any of these please advise us.
* If you choose to take your nutritional supplements (Sols) with you while traveling by air, make every attempt to take the nutritional supplements in your carry-on luggage. Please be aware that there is a risk of leakage and/or security check challenges. Occasional exposure to x-ray should not harm them. Please do not hesitate to contact us if you have questions.
* *No nutritional supplements (Sols) will be accepted for return*. It is the client’s responsibility to make sure that all their purchases are satisfactory and have been given to them. Once you leave the office, we will not be held responsible.
* I understand that the initial consultation and auricular medicine evaluation/follow-up will not be charged to my insurance company. I understand I will be financially obligated to pay the total amount in full.

By signing below I agree to receive invoices via electronic means and know I can always request a paper copy at the time of service. I also understand and accept the above for each transaction even if I do not physically sign the specific invoice.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client/Guardian Date