ANew Health

Health ~ Strength ~ Vitality

Adult Consent & Release of Liability Form

I, _____, consent for Tricia Trafford, FNP to consult with me regarding my health concerns. I understand and acknowledge that that all guidance, counsel, and advice that I receive from her is an Integrative Approach to Wellness. I understand that Tricia is not my Primary Care Provider and I agree to have my own Primary Care Provider so that in case of sickness and/or emergencies, I can receive the medical care that I need. I take responsibility for the decisions I make to improve my health.

Tricia will recommend professional-grade supplements for me to order directly from professional distributors. I release Tricia Trafford, FNP, ANew Health, and Wings of Healing Ministries from any and all liability and responsibility if I choose to order outside of her recommended products and guidelines.

I understand that Tricia adheres to professional guidelines in terms of frequency of appointments by phone and office. I agree to adhere to ANew Health's polices for telephone and office appointments.

I understand that ANew Health is part of the visin of Wings of Healing Ministries. I hereby release Wings of Healing Ministries, ANew Health, and Tricia Trafford, FNP, from any and all claims of actual or implied liability that may arise now or in the future as a result of the Integrative health care that I participate in.

I agree that I will not make for any reason a claim against, sue, or seek to attach the property of Wings of Healing Ministries, its agents, employees, officers, and directors. Furthermore, I agree that I will waive all actions, claims, or demands that I now or hereafter may have, for any injuries suffered by me during my voluntary participation to improve my health, resulting from negligent act(s), or omissions of any participant in ANew Health.

I have read this agreement and fully understand its contents. I am aware that this is a release from liability and an agreement between me and Tricia Trafford, which includes ANew Health, and Wings of Healing Ministries. I sign this agreement of my own free will, verifying that all information herein is accurate and true.

Name: _____

Please Print Your Name

Signed: _____ Date: _____

Witness: _____ Date: _____