

## RETREAT INTAKE

*Please completely fill out the form and consent below. If the consent is not filled out completely, we will need to return the form to you to complete before we can schedule you. Retreats must be scheduled at least 48 hours in advance. At this time we are only scheduling one person per time slot.*

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Pick up to four units for your retreat:

- Plant Walk                       Monthly Herbal Lesson                       Castor Oil Pack  
 Retreat Time                       Foot Bath, Steam Tent & Wet Sheet Wrap (2 units)  
 Herbal Steam & Foot Bath  
 Naturopathic Follow Up Consult  
 Naturopathic Initial Consult (2 units)—*fill out separate consent & intake form*

Phone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

Address (with City/Zip): \_\_\_\_\_

Preferred method of contact:  Phone  E-mail  US Mail

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Number: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Would you like to receive e-mail updates from Our Healing Roots, LLC?  Yes  No

Allergies: \_\_\_\_\_  
 \_\_\_\_\_

Check if you have any of the following...

- |   |   |
|---|---|
| <input type="checkbox"/> Activity physical limitations      | <input type="checkbox"/> Cancer                     |
| <input type="checkbox"/> Heart Disease                      | <input type="checkbox"/> Asthma or COPD             |
| <input type="checkbox"/> Heat or Cold Intolerance           | <input type="checkbox"/> Open Wounds                |
| <input type="checkbox"/> Contagious Skin Disease            | <input type="checkbox"/> Neuropathy/Loss of Feeling |
| <input type="checkbox"/> Blood pressure issues              | <input type="checkbox"/> Anxiety                    |
| <input type="checkbox"/> Chemical/environmental sensitivity | <input type="checkbox"/> Seasonal allergies         |
| <input type="checkbox"/> Carry an EpiPen                    | <input type="checkbox"/> Diabetes                   |

## CONSENT AND PAYMENT POLICY

I, \_\_\_\_\_, (client), consent to participate in a retreat provided from Katrina Bogdon, ND of Our Healing Roots, LLC. I understand that I will

not be receiving diagnostic information. Dr. Katrina Bogdon is licensed as a naturopathic physician in the state of Washington and she received her four years of post-graduate naturopathic medical education and two years of residency through CMNE approved programs.

I understand that the state of Missouri does not license NDs and that Dr. Katrina Bogdon is not a Medical Doctor (MD) nor Osteopathic Doctor (DO).

I also understand that I will not be receiving any medical treatment or prescriptions from Dr. Katrina Bogdon. I understand that I will not be receiving naturopathic recommendations unless I have signed up for a naturopathic consult during my retreat time.

\_\_\_\_ (initial) I understand that Dr. Katrina Bogdon does not carry medical malpractice insurance and is not required to by law.

I understand that if Katrina Bogdon, ND determines that I am in urgent need of medical evaluation, she will refer me to my primary care physician or the Emergency Room. I understand that I must consult with my licensed medical provider to obtain medical evaluation, medical diagnosis, and medical treatment. If you need urgent medical attention, call 911 or go to the nearest ER.

During hydrotherapy sessions (i.e. castor oil packs and wet sheet wraps), draping will be used as required to expose only the parts of my body that require treatment and/or as I choose to ensure my comfort. If at any time during the session, I feel uncomfortable for any reason, I have the right to request an immediate stop to the session or request modifications. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the retreat without refund of my money.

### **RETREAT LOCATION CONSIDERATIONS**

I understand that the retreat is located at a working small farm and residential business. I agree not to enter or open any animal pens or the barn. I understand that animal pens are lined with electric fencing that can result in electrical shock if touched.

\_\_\_\_ (initial) I assume all liability (including monetary damage, loss of animals, death or bodily injury) that results from opening gates or structures that contain animals as described above.

As the retreat is at a residential business location, I agree to come only during my scheduled appointment time. If I register for any plant walks or herbal sessions, I understand and consent to possible risk of an allergic or adverse reaction with plants. I consent to the risk of insect bites and/or snake bites on plant walks.

The information you learn in the plant walk, hydrotherapy, or herbal sessions is solely informational and educational. Katrina Bogdon, ND, and Our Healing Roots, LLC, assumes no liability or responsibility for the use or misuse of the information provided in these sessions.

### PAYMENT AND FEES

Our Healing Roots, LLC, accepts payment via cash, check, credit card, and debit card. Payment is due at the time that services are scheduled.

Three-hour retreat packages are priced at \$180.00. If the three-hour retreat package includes a initial naturopathic consult, the price is \$240.00.

### PRIVACY POLICY

For the privacy of your health information, text messages are blocked from the business phone.

I understand that the information I share with Our Healing Roots, LLC, will be kept confidential as described in the Notice of Privacy Practices. I understand that the Notice of Privacy practices is available for me to view upon request, in the office, and on this company's website.

### APPOINTMENTS/CANCELLATION

Your appointment time is reserved for you. Should you need to reschedule, please call at least 2 weeks before your retreat to get a full refund. If you cancel with less than 2 weeks prior to your retreat, you will receive a refund minus a \$30 cancellation fee. If you cancel less than 48 hours before your retreat, you will receive a 50% refund. If you do not call ahead to cancel prior to your appointment and you do not show up for your retreat, your money will not be refunded.

Signing my name below attests that I have read the foregoing and that I to my understand the information above. I agree to these terms and acknowledge that this document is a binding contract for service.

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

Dr. Katrina Bogdon, ND: \_\_\_\_\_ Date: \_\_\_\_\_

*Scan and e-mail this form to [office@ourhealingroots.net](mailto:office@ourhealingroots.net), fax to (844) 685-0298, mail to 760 Short State Hwy P; Seymour MO, 65745, OR turn the form in person at the 2BWell Front Desk (see hours and location at <http://www.ourhealingroots.net/contact.html>.)*