HOLISTIC
BREAST HEALTH

CLIENT INTAKE FORM – CONTACT INFO

Name _____ Age: _____

Today's Date: _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Numbers: HOME: _____

CELL: _____

Who Referred You to Holistic Breast Health? _____

ENCRYPTED REPORTS ARE SENT TO CLIENTS VIA SHAREFILE

E-mail Address: _____

I understand that the risk assessment evaluation report generated from my images are intended for use by trained health care providers to assist in evaluation, diagnosis and treatment. I further understand that the report does not provide diagnosis of disease, eliminate the possibly that disease is present and that the report is not intended for self diagnosis or self evaluation.

Payment is due at time of services rendered in Charlotte and prepayment required in Chapel Hill.

I give Holistic Breast Health permission to send a copy of my Report to the following people:

NAME	EMAIL ADDRESS

Signature_____ Date:_____