Imagine Wellness

PATTY ANN FORD

Financial Disclosure

I, _____ (name of client) understand that I am solely responsible for all financial charges for coaching, counseling, and or dietary consult services provided if _____ (name of insurance) refuses to pay.

Signatures:

_____

Patient Signature **Date**

Name of Parent or Gaurdian:

_____

Parent or Legal Gaurdian Signature **Date**

_____

Dr. Patricia Ford, MPH, RD Signature **Date**