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**Acknowledgments**

**Acknowledgement of Relationship**

I understand that Heather Krantz, M.D. is NOT my physician (primary care or otherwise) or my mental health caregiver, and that Dr. Krantz is acting solely as an educator about mindfulness, mind-body medicine, and integrative care. Dr. Krantz will not be prescribing any treatment or medications for me.

**Privacy Statement:** While the nature of your visit is educational, Dr. Krantz does respect your privacy and will only release information about your visit at your request.

**Financial Responsibility:**  I understand and agree that I am responsible for all charges incurred for all educational services rendered by Dr. Krantz, and that payment is expected at time of service. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for Dr. Krantz to take action to secure payment of an outstanding balance owed.

**Cancellation Fee**: A cancellation fee of $25 will be assessed for missed appointments not canceled with more than 24 hours notice.

**No Guarantees**: I am aware that no practice of medicine is an exact science, and acknowledge that there are and can be no guarantees as to accuracy or outcomes of any diagnoses or treatments I receive.

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

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Signature

Patient/Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name Printed

Patient/Guardian

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Relationship