



Tina Spathis RN, DCH
#201- 2786 W 16th Ave Vancouver, BC V6K 4M1
604-786-6095

Patient Name: _____

Address: _____

Postal Code: _____

Home Phone: _____ Work or Cell: _____

Email: _____

Date of Birth: _____ Age: _____

Occupation: _____ Hours worked per week: _____

If child, name of Parent or Guardian: _____

Referred by: _____

Current Physician and phone number: _____

I, the undersigned, understand that Tina Spathis is a professional homeopath trained in the classical tradition, and is not a licensed medical doctor. As such, I acknowledge that it is my responsibility to seek medical diagnosis and advice for my present and future conditions. In consulting with a professional homeopath I am exercising my right to choose an alternative method of treatment through which to address my total health. As homeopathy is not covered by the existing medical insurance plan, I agree to pay all fees at the time service is rendered payable by cash or cheque, as well as charges incurred for missed or cancelled appointments without sufficient notice (24 hours notice).

Signature: _____ Date: _____