

A New You Holistic Weight Loss Program



Susan Tyler, CQBS, Diplomate, CNC, Weight Loss Coach
541) 733-4207
www.hcgsresults.com

Name: _____ Birthdate: _____
Street Address: _____ City: _____
Zip Code: _____ Telephone #: _____ Cell: _____
Email: _____
Current Weight: _____ Desired Weight: _____ Menses due: _____
Medications currently taking and reason: _____

Supplementation currently taking and reason: _____

Please initial each line after you have read and understood each item:

___ I have been explained the Weight Loss Program to my satisfaction.

___ I have had all my questions answered to my satisfaction.

___ I realize I will be making lifestyle and dietary changes according to the program and agree to follow the coaching I receive to achieve successful weight loss.

___ I am tired of being overweight and I am ready to do what it takes for me to achieve my perfect weight and size.

___ I acknowledge that I am seeking this service for my own good and by my own will as a choice that I feel is appropriate for me and no one has coerced me into joining this program.

___ I agree to have my weight, measurement, before and after photo taken for purposes of the program. This is protected information that is not released to anyone without my written consent.

___ I understand that I am entering into an agreement for Biofeedback, Voice Stress Repatterning, Homeopathic Remedies, Nutritional Supplements, and other items as deemed necessary to complete the program and that no guarantees, implied or otherwise have been made.

I agree to hold harmless any and all persons involved in this Holistic Weight Loss Program for any misunderstanding, disagreement, physical, emotional or mental concern that surfaces as a result of doing the program. I recognize that weight loss is a complicated issue with many causes and that this program, while proven safe for thousands of people before me, may not address my specific issues.

I understand I have the right to stop the program at any time.

I understand and agree there are no refunds of any money if I do not complete the program for any reason.

I understand the need to complete the detoxification steps in Phase 1 to ensure my best results. I have been advised that to shortcut this step will result in less than hoped for results.

I understand and agree that anyone associated with the program, its directors and associates are wellness and weight loss coaches only. Questions of a medical nature must be directed to my licensed health care provider.

Saliva Hormone Testing is provided as part of the program prior to beginning Phase 1. This is required to ensure that I have the best results. Any suggested prescription by the attending licensed practitioner is at an additional charge and is not included with this program.

I agree to seek the advice of my licensed health care provider prior to starting the program. If I am currently under care for a health concern, I may be required to provide a medical release prior to starting this program.

I am agreeing to this Program for Holistic Weight Loss Y N

The Program total is: \$_____ Please initial here to confirm your acceptance_____

Circle Method of Payment: Cash Check Visa Master Card

To pay by Credit Card please enter information here:

Name on Card: _____

Credit Card: Visa MC Expiration Date: _____ CVS (Security code on back of card): _____

Credit Card # _____

Does billing go to same address: Yes No (if No, please enter billing address below

Thank you! I look forward to your successful transition to A New You! *Susan*

A NEW YOU HOLISTIC WEIGHT LOSS PROGRAM

