

CARING HOLISTIC SERVICES

Last Name: _____ First Name: _____ Phone: () _____

Street Address: _____ City: _____ State: _____ Zip: _____

NAME (s): _____ BREED: _____ age: _____ sex: _____ Color: _____

I understand that Dr. Roger DeHaan provides orthodox, complementary, integrative and holistic services. This includes complimentary therapies: including nutrition, chiropractic, acupuncture, homeopathy, prolotherapy, laser therapy, flower remedies, herbs, natures medicine and more.

I understand that payments are to sustain and support the services I have requested.
It is also understood that no claims of restoration of health can be guaranteed.

Signature: _____ Date: _____