

Dear HP Families,

We are pleased to offer you the Homeoprophylaxis (HP) program as overseen by Free and Healthy Children International: a forty-four-month self-administered program to educate the immune system towards infectious contagious disease.

Included is a personal membership and waiver form for the Certified HP Supervisor who will remain your point of contact for the duration of the program. Your HP Supervisor is on hand for questions and support relating to the administration of the program, dosing, and remedy responses, if needed. They are also available for private consultations regarding other health matters as delineated by their posted fee schedule

We thank you for your willingness to explore an alternative method of educating your child(ren)'s immune system(s) through the systematic use of Homeopathic nosodes. We thank you for partaking in a cultural shift of the vaccine paradigm regarding how to keep infectious disease incidence low while also improving the long-term health outcomes of your children.

FHCi has been doing research on HP since 2009 and will have results published sometime in 2018. FHCi is a 501(c)(3) Charitable Organization offering membership to its HP Supervisors and all families wishing to pursue the use of HP for their children. The following forms explain this relationship and the rights, benefits and responsibilities of your participation.

Thank you,

The FHCi Board of Directors

Free and Healthy Children International

1614 Harmon Place, Suite 204

Minneapolis MN, 55403

<http://freeandhealthychildren.org/>

IRS 501(c)(3) Non-Profit

EIN 46-2093772

Free and Healthy Children International Membership Agreement/Waiver Form

Overview

For membership fee paid, I do hereby apply for membership on behalf of myself and my children in Free and Healthy Children International (FHCi), hereafter termed “The Association,” a private membership organization governed under the IRS 501(c)(3) tax code for the purpose of access to the homeoprophylaxis program (HP) as outlined by FHCi. With the signing of this membership agreement and receipt of payment by an existing FHCi HP Supervisor, I accept the offer made to become a member of FHCi and have read and agree with the following Declaration of Purpose of FHCi, Preamble and Memorandum of Understanding.

Declaration of Purpose: Free and Healthy Children International is dedicated to research, education and access to Homeoprophylaxis. FHCi is not licensed as a dispensary, however membership with our organization entitles all members to have access to all medicaments and supervision made available under the umbrella of The Association. FHCi works in partnership with homeopathic pharmacies who provide the program remedies.

Chapter Five: HP Family Membership

5.1: New HP Families: By consenting to the Membership Agreement provided to families wishing to partake in the HP program with FHCi, HP Family Members are granted Membership. The non-refundable fee of \$35, which is included in the initial supervision portion of the HP program for HP Family Membership, is to be collected by their selected HP Supervisor and transferred to FHCi at the time of HP Family Member’s consent and purchase. This fee grants the HP Family Member and their enrolled children the following rights and benefits:

- Access to your chosen FHCi HP Supervisor for HP program needs.
- Complete access to the HP program, related printed materials, and Homeoprophylaxis nosodes sufficient for the program
- Ongoing supervision for their child(ren) undertaking the program for questions and support pertaining to the program, with a certified HP Supervisor
- Right to detailed informed consent about the HP Program, remedy responses, and what to expect
- Right to a coordinated transfer to a substitute HP Supervisor, according to the specifics outlined in the FHCi bylaws
- Right to access our Ethical Review Process if you feel your HP supervisor has willfully or unintentionally neglected the appropriate and needed supervision of the program
- Complaints against an HP supervisor must be submitted in writing to FHCi within three months of the incident of complaint. These will be sent to the Ethics Review Committee for evaluation and remediation action.
- Right to access our Adverse Event Reporting Process if there has been an adverse event above and beyond normal immunological stimulation expected from the use of HP Nosodes. **Definition:** *An adverse event is defined as a death, life-threatening adverse drug or device experience, inpatient hospitalization or prolongation of existing hospitalization, a persistent disability/incapacity, or a congenital anomaly/birth defect*
- Adverse Event Reports must be submitted in writing to FHCi within three months of the incident of complaint. These will be sent to the Adverse Event Review Committee for evaluation and published according to the Adverse Events Reporting Procedure.
- Upon request, access to the Association’s Bylaws and public records
- Subscription to the FHCi family newsletter (Email)
- Access to participation in community gatherings and social media groups (Public or Private) to connect and relate with other HP Family Members to share and discuss the use and experiences of HP.

- FHCi Annual report (E-copy)
- Guarantee that all Personal Health Information (PHI) submitted to your HP Supervisor Records of the HP Family Membership agreement and PHI submitted at time of registration are to remain in the custody and in the confidential holding of the HP Supervisor member. With the exception that FHCi holds the right to access non-PHI for research purposes but may be called upon for review by FHCi for any research activity. Personal Health Information of all Family Members will be held in strict confidentiality and will remain private from any State Medical Board, the FDA, FTC, Medicare, Medicaid or insurance companies without the previously expressed specific permission granted by the Family Member.
- Membership with FHCi will remain intact unless the family member submits in writing their desire to withdraw membership. Withdrawal of Membership prior to completion or of the program does not negate any agreements made regarding access to previous and existing participation in the HP Program. Withdrawal of HP Family Membership includes removal from all social media platforms that membership entails. They would still have access to HP Supervision for 50 months starting from the date that they signed up for the program. The fees for participating in the FHCi HP Program are non-refundable, including the FHCi Family Membership fee, the HP Supervision fee, the HP Program booklet fee, the HP Remedy Kit fee and any other fees for extra remedies ordered and shipping of remedies and booklet.

5.2: FHCi HP Supervisor -HP Family Membership Relationship: FHCi HP Supervisors are committed to serve their registered families for a reasonable duration of the completion of the program for the initial supervision fee the family has paid. For registration of subsequent children enrolled after the first, and within the first 50 months, the second-tier supervision fee is paid. This member to member relationship, based on supervision of the registered children in the program expires 50 months after initial registration date. For additional children enrolled 5 years, or more, past the initial registration, the HP Supervisor can recharge total initial supervision fee again.

Preamble

We believe that the First Amendment of the Constitution of the United States of America guarantees our members the rights of free speech, petition, assembly, and the right to gather together for the lawful purpose of advising and helping one another in asserting our rights under the Federal and State Constitutions and Statutes. IT IS HEREBY DECLARED that we are exercising our right of “freedom of association” as guaranteed by the 1st and 14th Amendments of the U.S. Constitution and equivalent provisions of the various State Constitutions. This means that our association activities are restricted to the private domain only.

We proclaim the freedom to choose for ourselves the types of products, therapies and self-help modalities that we think best. We encourage our members to perform their own research by studying different resources to prevent illness, diseases of our minds and bodies, and for achieving and maintaining optimum wellness. We proclaim and reserve the right to include health options that include, but are not limited to: cutting edge treatment modalities and therapies practiced or used by any types of healers or therapists or practitioners the world over whether traditional or nontraditional, conventional or unconventional. While most of the Homeopathic nosodes used in the HP program are registered with the FDA under the HPUS there may be a time when the FTC or FDA limits access or availability of these products. The Association is dedicated to ensuring continued access to HP.

Specifically, the mission of The Association is to change existing life circumstances through teaching alternative health awareness, which enables members to improve their physical well-being and to provide members with the highest level of research and the most effective modalities for prevention. The Association will recognize any person (irrespective of age, race, creed, gender, sexual orientation or religion) who acts in accordance with these principles and policies as a member, and will provide a medium

through which its individual members may associate for actuating and bringing to fruition the purposes heretofore declared.

Memorandum of Understanding

I understand that _____ Shelly Garrison CCH _____ is the HP Supervisor for the administration of this program.

I understand that she is not a medical doctor. However, she practices Homeopathy and Homeoprophylaxis in accordance with State or provincial: (indicate law here) _____ Health Freedom Act - California SB-577 _____

_____ is offering to me the HP Program as outlined by Free and Healthy Children International (FHCi). And She/He is an agent of FHCi for the administration of the HP program and will serve to be my direct point of contact for any questions regarding the administration of the program or reaction that may occur.

- € I understand that within The Association no doctor-patient relationship exists but only a contract member to member association relationship. I have freely chosen to change my legal status as a public patient, customer or client to a private member of The Association.
- € I understand that, since The Association is protected by the First and Fourteenth Amendments to the U.S. Constitution, it is outside the jurisdiction and authority of Federal and State Agencies and Authorities concerning any and all complaints or grievances against The Association, any Trustee(s), members or other staff persons. All rights of complaints or grievances will be settled by an Association Committee and will be waived by the member for the benefit of The Association and its members. By agreeing to this membership form I agree that I have sought sufficient education to determine that this is the course of action I want to take for my children.
- € Because the privacy and security of membership records maintained within The Association, which are held to be inviolate by the U.S. Supreme Court, the undersigned member waives HIPAA privacy rights and complaint process. However, any medical or healthcare records kept by members of The Association will be strictly protected and only released upon written request of myself as member.
- € I agree that violation of any waivers in this membership contract will result in a no contest legal proceeding against me.
- € The Association does not participate in any medical insurance plans or collections on behalf of the member but will provide a suitable invoice for the member to pursue reimbursement by his/her insurance company, if applicable.
- € Other aspects of informed consent will take place in my discussions with the providers and my fellow members of The Association.
- € As I am voluntarily choosing this method of disease prevention, I will not hold the HP Supervisor or FHCi financially liable for any particular outcome regarding the health of my child.
- € I understand the purpose of HP is to stimulate my child's health and immune system so that it will become less susceptible to contracting infectious contagious disease. This immunological stimulation is intended to demonstrate healthy immune response such as mild fevers, discharges, mild mood and energy influxes as the child reconciles the disease agent. These reactions are short lived (12-48 hours) and demonstrate healthy immune function.
- € I agree to contact my HP Supervisor for any immunological reactions I have concerns about.
- € I understand that no method of prevention can be guaranteed to be 100% effective, vaccination or HP, and that my child, if exposed to a particular infectious contagious disease, may in fact contract the disease. I also understand that with any form of prevention there are risks and reactions that may occur.
- € I agree to discuss my concerns with the HP Supervisor and to seek appropriate medical treatment, homeopathic or otherwise, should the need arise.

I agree to join The Association, a private membership association under common law, whose members seek to help each other achieve better health and good quality of life.

My activities within The Association are a private matter that I refuse to share with the State Medical Board, the FDA, FTC, Medicare, Medicaid or my own insurance company without my expressed specific permission. All records and documents remain as property of The Association, even if I receive a copy of them. I fully agree not to file a malpractice lawsuit against a fellow member of The Association, unless that member has exposed me to a clear and present danger of substantive evil.

I enter into this agreement of my own free will on behalf of my dependent without any pressure or promise of cure or disease prevention. I affirm that I do not represent any State or Federal agency whose purpose is to regulate and approve products, or to carry out any mission of entrapment or investigation. I have read and understood this document, and my questions have been answered fully to my satisfaction. I understand that I can withdraw from this agreement and terminate my membership in this association at any time, and that my membership can and will be revoked if I engage in abusive, violent, menacing, destructive or harassing behavior towards any other member of The Association. These pages consist of the entire agreement for my membership in The Association.

Payment of the program costs and delivery of these signed documents to an HP Supervisor is considered sufficient for my one-time membership contract for the duration of participation of the Homeoprophylaxis Program as outlined by FHCi. Term begins with the date of submission of this contract.

Parent's Name: _____

Mailing Address: _____

City _____ State _____ Zip Code: _____

Phone Number: _____ E-mail: _____

Child's Name: _____ Date of Birth _____ Start age (Months) _____

Child's Name: _____ Date of Birth _____ Start age (Months) _____

Child's Name: _____ Date of Birth _____ Start age (Months) _____

Child's Name: _____ Date of Birth _____ Start age (Months) _____

Signature

Date

Relationship to child(ren) _____

Witnessed

HP Supervisor's Address and contact info

Shelly Garrison, CCH

PO BOX 363, FORT BRAGG, CA 95437 1.707.962.0236 shellyg@mcn.org

Initial Health Profile (one form per child)

A. File number _____ B. Date _____ C. HP Supervisor _____

D. Name of child _____ E. Sex _____ F1. DOB _____ F2. Age at time of registration _____

G. (circle all that apply): Home Birth; Hospital Birth; Caesarian Birth; Born Full-Term; Born Premature.

H1. List all vaccinations, vitamin K shot, antibiotics & other medications child has received and number of each: _____

H2. List all vaccinations, antibiotics and other medications mother received while pregnant or in labor: _____

H3. Child given: (circle all that apply and number of months): Breast milk _____, Milk-formula _____, Soy-formula _____

H4. Please indicate if your child has been exposed to or contracted any of the following diseases and the dates:

Polio _____, Streptococcal disease _____, Whooping cough _____, Pneumonia _____,
Haemophilus Inf B _____, Meningitis _____, Tetanus _____, Mumps _____, Measles _____,
Other (please indicate) _____

Please indicate if your child experiences any of the following, how often, and what degree of intensity. Indicate Current or Past. (C/P)

Frequency

- 0 - Never
- 1 - Rarely; 1-2 times /year
- 2 - Occasionally; 3-6 times/year
- 3 - Frequently; once a month
- 4 - Chronically; all the time

Intensity (if at all) If never leave blank

- i - almost not noticeable
- ii - mild symptoms
- iii - moderate intensity
- iv -severe

I) Ear infections **C/P**

0, 1, 2, 3, 4

K) Colds/sore throats/coughs

0, 1, 2, 3, 4

M) Seasonal allergies **C/P**

0, 1, 2, 3, 4

O) Type of Allergy _____

P) Food allergies; **C/P**

0, 1, 2, 3, 4

R) Indicate which ones _____

S) Asthma **C/P**

0, 1, 2, 3, 4

U) Eczema **C/P**

0, 1, 2, 3, 4

Behavioral conditions

W) Violence **C/P**

0, 1, 2, 3, 4

Y) Mood swings **C/P**

0, 1, 2, 3, 4

AA) Fears **C/P**

0, 1, 2, 3, 4

Learning disorders

AC) speech delay **C/P**

0, i, ii, iii, iv

AD) disturbance in cognitive function **C/P**

0, i, ii, iii, iv

AE) disturbance in social function **C/P**

0, i, ii, iii, iv

Neurological conditions **C/P**

AF) 0, 1, 2, 3, 4

J)

i, ii, iii, iv

L)

i, ii, iii, iv

N)

i, ii, iii, iv

Q)

i, ii, iii, iv

T)

i, ii, iii, iv

V)

i, ii, iii, iv

X)

i, ii, iii, iv

Z)

i, ii, iii, iv

AB)

i, ii, iii, iv

AG) i, ii, iii, iv

Use this area when you need extra space for listing vaccines, etc., or explaining considerations in your child's health condition.

Submit to HP Supervisor, with Membership/Waiver form upon registration and keep a copy for yourself.

Fee Schedule for Homeoprophylaxis Program

Homeoprophylaxis program includes:

HP Program Booklet, Status Sheet, Membership Agreement, HP Supervisor's Credentials and Fees.

Also included: Remedy Kit with sufficient remedy doses for 4 years of Homeoprophylaxis.

Initial brief consultation and intermittent telephone inquiries regarding the program for entire course of the program. **(Modify per supervisor as needed)**

Check here if you would like to make an additional donation to FHCi to support the development of HP. Donations go towards general administrative costs and research analysis. Suggested donation is \$20.

4. Fees and Costs: These are relative to each country and currency equivalent.

Material cost is the same regardless of country, the Practitioner fees vary based on local economy.

<p>HP Supervision fee</p> <p>One-time fee (for up to 4 children) in the same family at time of registration</p>	<p>Family of 4 £225+ \$35, or 255€ +\$35 or \$300 + \$35</p> <p>See following table for additional pricing options</p>	<p>1 child + 1 or more children: £150, one child + £75 170€ one child, + 85€ \$ 200 one child +\$100 + \$35 FM fee per family (US dollar) for all nationalities.</p>
<p>1. Booklet per child 2. Additional child</p>	<p>\$13.20, or £10.00, 11 € for first child \$5.40, £3.99 or 4.53€ for additional children</p>	
<p>HP Kit (Need a second kit for more than 4 children)</p>	<p>\$111 kit includes Tub and Strep Check for currency exchange</p>	
<p>Additional remedies not in the main programme or replacement vials</p>	<p>\$9 each Check for currency exchange</p>	
<p>Shipping</p>	<p>\$8.95 -\$49.50 depending. Check for currency exchange</p>	
<p>Additional surcharge for city or rural</p>	<p>Max \$100, £100, €100</p>	
<p>Practitioners can reduce base cost on a sliding scale fee if they feel it necessary</p>	<p>Reduce base fee up to \$100, or £100, or €100</p>	
<p>Cost: = HP Supervision+ Booklet per child+ HP kit (4 children) + Shipping</p>		

Fees for Homeoprophylaxis Program and remedies are non-refundable regardless of continuation in program. Remedy Kits are non-refundable after point of sale. Your Membership with FHCi will remain intact unless you submit in writing your desire to withdraw Membership. Withdrawal of Membership prior

to completion of the program does not negate any agreements made regarding access to or previous and existing participation in the HP Program.

Alternative fee schedule for initial and additional scheduled HP consult visits.							
	Initial 30 min registration + options of additional 15 min appts. (\$55 or \$75) 2, 4, or 6 additional appts in the first 16 months		Fee for extra visits	Single payment no scheduled visits. (random calls and emails included)	Initial + 2 scheduled follow-ups	Initial + 4 scheduled follow-ups	Initial + 6 scheduled follow-ups
1	Option one: base cost	Supervision base cost for one child, <u>OR</u> two or more.		\$200 one child +\$100 additional children	\$160 +\$100	\$160 +\$100	\$160 +\$100
		Additional visits	\$55 per visit		\$110	\$220	\$330
		Totals for first child, <u>OR</u> two or more children		\$200 or \$300	\$270.00 Or \$370	\$380 Or \$480	\$490 Or \$590
2	Option two: Elevated HP consult base cost + surcharge fee	Supervision Base cost for one child <u>OR</u> two or more.		\$300 one child +\$100 additional children	\$260 +\$100	\$260 +\$100	\$260 +\$100
		Extended consult	\$75 per visit		\$150	\$300	\$450
		Totals for first child, <u>OR</u> two or more children		\$300 or \$400	\$410.00 Or \$510	\$560 Or \$660	\$710 Or \$810
3	For 10M series	For remaining 24 months	\$55 or \$75 for consults		+\$110 Or \$150	+\$220 Or \$300	+\$330 Or \$610

Regular office fees for HP Supervisor:

STATEMENT OF OFFICE FEES

Shelly Garrison, CCH

CLASSICAL HOMEOPATHY CONSULTATIONS –

Initial Intake (1 hour 15')	-	\$125
Follow Up Consultations (40')	-	\$ 65
Acute Care Appointment (20')	-	\$ 45
Text or Email Prescription	-	\$ 15
Homeopathic Remedy Packaging	-	\$ 10 - \$15

Credentials, Affiliations and Associations

For HP Supervisor

Shelly Garrison, CCH

Phone number 707.962.0236

Email: shellyg@mcn.org

2018 - CCH, Certified Classical Homeopath, Council for Homeopathic Certification (CHC)

2010 – 2017 - EWH, East West Homeopathy – Board of Directors 2010-2017

2008 – 2012 - Dr. Issac’s Academy of Homeopathy, graduate and Certificate of Completion

2016 - CEASE Certified - Homeopathic Isotherapy Detox

2014 - FHCi, Free and Healthy Children International, HP Supervisor, C.HP

2014 - NCH, National Center for Homeopathy

2014 - CHMS, California Homeopathic Medical Society

2014 - BAHA, Bay Area Homeopathic Association

1984 – 1985 - UCSC, University California Santa Cruz

1982 – 1984 - Victor Valley College, AA Degree

Shelly Garrison, CCH

Client Contact Information & Disclosure

Name: _____ Date: _____

Date of Birth: _____ Age: _____

Phone / Cell / Text : _____

Email Address: _____

Address: _____

City, State, Zip Code : _____

Occupation: _____

Referred by: _____

Responsible Party (Parent or Caregiver):

Name: _____ Relationship: _____

Address: _____

Phone: _____ Cell: _____

Emergency Contact: _____ Relationship: _____

Acknowledgement

The homeopathic service you have requested works upon your constitution and vitality. Law prohibits the homeopath from diagnosing or treating disease. Homeopathy is not licensed in the USA and the homeopath is not a medically licensed physician. For such a service you may choose to consult with your allopathic physician. My practice is in compliance with the law and the Health Freedom Act of California, Senate Bill 577, Section 2053.6. It is based on the science of homeopathy as defined by Dr. Samuel Hahnemann in the Organon of Medicine. I am certified as a classical homeopath, CCH, by the Council for Homeopathic Certification. My casework may be shared with Dr. Jose Issac, (Hom), with whom I maintain study and ongoing work.

“It is my preference to use the homeopathic services provided by Shelly Garrison, CCH. I understand that her homeopathic services are not the same as allopathic medical treatment that the homeopath is not a licensed medical physician but *is* a trained professional homeopath.”

I acknowledge that I have read and agree to Shelly Garrison’s policies and understand that I am responsible for the associated fees when I receive her services.

Name (PRINT) : _____ Self / Parent / Guardian

Sign: _____ Self / Parent / Guardian

Date: _____