



Dr. Herman Spies

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Integrated Medical Practice

* Medical Doctor * Doctor of Chinese Medicine * Acupuncture * Homeopath * Iridology * Homotoxology * Functional Medicine * Quantec Test *
* Electro Interstitial Scan * Hulda Clark Protocols * Biopuncture * Q2 Detoxification * Ozone Treatment * Intravenous Vitamin C & H2O2 *
* Resonator Therapy * Bemer Electro-Magnetic Pulse Therapy * Lymph Pressure Massage * Bioptron VIP Light Therapy *

Dear Patient,

RE: TESTIMONIAL ON WEBSITE

Thank you very much for your willingness to give us a testimonial that we can use on our website. It can be as short as one sentence, we don't mind!

Please indicate if you are willing to let us use the following information on the website:

1. Your name: Yes / No (If Yes, please indicate how your name may appear:

_____)

2. Location/town where you live: Yes / No (If Yes, please state town: _____)

3. Description of your type of problem (e.g. allergy/asthma): Yes / No (If Yes, please name problem:

_____)

4. Contact details: Mobile no.: Yes / No (If Yes, please give number: _____)

eMail address: Yes / No (If Yes, please give address: _____)

5. Your Photo on our file: Yes / No

6. Video Clip (if we have one): Yes / No

7. Testimonial: _____

I (Name: _____) hereby give Dr Spies permission to use my testimonial on his website. The consented Information may be displayed, until I request in writing that it is removed.

Signed (Place: _____) on this day: ____/____/201____.

Signature: _____.