PATIENT INTRODUCTION

□ Mr. Date _____
□ Mrs.
□ Miss _____ Age____
First Middle Maiden Last
□ Single □ Married □ Separated □ Divorced □ Widowed

Address _____
STREET CITY ZIP

Home Phone _____ Cell Phone _____

DATE OF BIRTH _____ REFERRED BY_____
ARE YOU MEDICARE ELIGIBLE? ☐ YES ☐ NO

Social Security No. _____ Driver's License No. _____

Place of Employment_____Occupation _____

Business Address _____
STREET CITY ZIP

Business Phone _____ E-mail Address _____

Name of person legally and financially responsible (*If patient is a minor, name of parent, guardian, etc.*)

_____

Name of spouse _____Date of Birth _____Occupation_____

Spouse's employer _____ Business Phone _____

Cell _____
STREET CITY ZIP

Name of nearest relative not living with you _____

_____
ADDRESS PHONE

MEDICAL HISTORY

Previous Injuries _____
Previous Back Pain _____
Illnesses _____
Operations _____
Medication(s) _____
Other Physicians _____
Known Abnormalities _____
PURPOSE OF THIS APPOINTMENT _____
When did your current symptoms begin? _____
Other doctors seen for this condition _____
Have you been treated by a physician for any health condition in the last year?
□YES □NO If yes, please describe _____

Have you ever suffered from:

□ Dizziness	□ Arthritis	□ Digestive Disorders
□ Backaches	□ Headaches	□ Nervousness
□ Heart Trouble	□ Numbness	□ Sinus Trouble
□ Diabetes	□ Asthma	□ Anemia
□ Tuberculosis	□ Neuritis	□ Rheumatic Fever
		□ Cancer

Informed Consent and Waiver of Liability

I hereby agree to the following:

1. That I am voluntarily requesting that I be allowed to participate in low level electromagnetic field (EMF) exposure via the Resonator™ or Magnesphere™ for "ENHANCING FEELINGS OF RELAXATION", provided by Pico-Tesla Magnetic Therapies, LLC and/or its customers, partners, subsidiary or affiliates, and (insert Healthcare provider name) (hereinafter "Companies").
2. I understand that there are no known or anticipated medical risks with exposure to the EMF. I also understand that the Companies do not know all of the consequences from its use. The FDA has not decided that the Resonator™ or Magnesphere™ devices or exposure to them are "safe." It is possible that I may suffer discomfort or pain, but it is not likely. Severe Injury could occur, but it is extremely unlikely.
3. I do not have any of the following Health Conditions, and understand that Relaxation Sessions are NOT recommended for those that have:
   * Implanted electrical stimulators in the Brain
   * Chronic Atrial Fibrillation (Uncontrolled)
   * Epilepsy
   * CHF (Congestive Heart Failure)
   * High Blood Pressure (Uncontrolled
4. In consideration of being permitted to participate in the EMF exposure, I agree to assume full responsibility for any risks, injuries, or damages, direct or indirect, known or unknown, which I might incur as a result of receiving this exposure.
5. In further consideration of being permitted to participate in EMF sessions through the Companies, I knowingly, voluntarily and expressly waive any claim I, my heirs, or legal representatives may have against Companies, Pico-Tesla Magnetic Therapies its customers, subsidiaries, affiliates, Licensors, Licensees, owners, directors, or representatives for any injury, death or damages that I may sustain as a result of participation, and forever release, waive, discharge, and covenant not sue said entities or individuals.
6. HIPPA Privacy Practices and Authorization to Use/Release Health Information: I acknowledge that I was provided with a copy of the Privacy Practices and Authorization to Use/Release Health Information acknowledging that Pico-Tesla continues its good faith effort to comply with the requirements of Federal Privacy Law. Per my execution of said document I hereby consent use and disclosure of my health information for the purposes and activities permitted under Federal Privacy Law, which are described in the Privacy Practices.
7. This product and its magnetic field exposures have not been evaluated by the FDA.
8. This product and its magnetic field exposures is not intended to "diagnose, treat, cure or prevent any disease,"
9. While participating in Relaxation Sessions, I understand that I should continue to follow (ie do not change) the drug or treatment regimens prescribed by my physician.

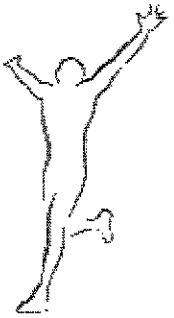
I have read the above informed consent and waiver of liability and fully understand its contents. I voluntarily agree to the terms and conditions stated above as shown by my signature below.

Signature of Patient _____ Date _____

___/____ (month/Yr of Birth)

____ ____ Last 4 digits of phone number

___ (sex M/F)



WHOLE HEALTH ALTERNATIVES II, LLC

Whole Health Alternatives II, LLC is not a provider of any one insurance. It is important that there be a clear understanding of this, and as a result, a clear understanding of what our procedures are regarding insurance.

You will always be informed of what procedures will be performed before they occur, and you will be informed of the fees associated with those procedures. You are responsible for payment on the date of services.

We do not process insurance forms at this office, nor do we have interactions with insurance companies. Each visit or periodically, we can provide you with an itemized receipt (a "Superbill") with all of the necessary codes and information for you to submit to your insurance company. Your insurance company may reimburse you for a portion of your office visit if you have out-of-network benefits. You assume sole responsibility for obtaining the receipt from us, interacting with your insurance company, and pursuing reimbursement. We do not guarantee reimbursement, although some of our patients do have success.

Ultimately your health choices are yours alone, not any insurance company, their representatives, or a policy manual.

By signing this form, you acknowledge that you are responsible for payment of services rendered and there is no guarantee that your insurance company will reimburse you for any procedures and treatment.

_____ _____

Patient Name Date

_____

Patient Signature