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

WHOLE HEALTH ALTERNATIVES II, LLC

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Orlando, FL 32835
Phone: (407)298-3090/Fax: (321)293-0111

NEURO EMOTIONAL TECHNIQUE CONSENT

Neuro Emotional Technique is a system of health-success methodologies which includes the finding and removing of neurological aberrations called Neuro Emotional Complexes (N.E.C.s) in the human organism. N.E.C.s have, as a component part, a spinal subluxation. These aberrations have, as a component part, specific emotional neurophysiological patterns. The technique ultimately is a methodology of making rational and physiologically emotional functions congruent via spinal adjustments.

Emotions are physiologically based functions which normally do not present any neurophysiological problems. Occasionally, emotional trauma in the presence of neurological deficit (lowered resistance) causes a neurological pattern (N.E.C) in the body which does not resolve of itself. The result is an embodied non-extinguished conditioned response. These old, unresolved responses interfere with the central nervous system's ability to function properly in various everyday recreational and workplace situations.

N.E.T. seeks to normalize this pattern via spinal adjustments which in turn affect a physiological change, resulting in a new ability to utilize your own success concepts.

Emotions also have a psychological aspect. However, this technology is not psychology or psychiatry. It does not involve any type of psychotherapy or a "talk-it-out" approach to emotions. Psychological aspects of emotional health will be referred out to appropriate health care professionals, such as a psychologist or psychiatrist.

Additionally, this technique does not deal with the spiritual realm. It does not exorcise demons or entities. It does not predict the future or deal in any way with the occult or parapsychology. It does not make any claims as to what events may have historically happened in the past. It does not tell people what their psychological plan of action may, must, or should be for the future.

To present, there have been no formal scientific protocol studies completed that validates the efficacy of this technique. The value is to be determined by the client utilizing the technique, ideas, and concepts of the physician.

In addition, the services provided by the attending physician are considered "elective" procedures and not reimbursable by insurance companies. Should an insurance company be mistakenly billed for these services, it is likely a letter will be sent to the physician requesting a report of service. The physician will reply that the services rendered were elective in nature and attach a copy of this disclaimer.

I have read this and consent to the concepts and disclaimers presented above. I intend for this consent form to cover this visit and any future visits for which I present.

To be completed by patient's representative if patient is a minor or is physically or mentally incapacitated.

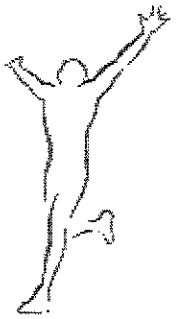
Patient's Signature _____ Date _____

Witness Signature _____ Date _____

Name of Patient _____

Signature of Patient's Representative _____

Relationship to Patient _____



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