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

WHOLE HEALTH ALTERNATIVES II, LLC

Marvin R. Terry, D.C.

2295 South Hiawassee Road, Suite 205
Orlando, FL 32835
Phone: (407)298-3090/Fax: (321)293-0111

NUTRITIONAL INFORMED CONSENT

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "drug" is defined to mean:

Articles intended for use in the diagnostics, cure, mitigation, treatment or prevention of disease. A vitamin, mineral, trace element, enzyme, amino acid, herb, or homeopathic remedy is not a drug. Although, a vitamin, mineral, trace mineral, enzyme, amino acid, herb, or homeopathic remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as any primary treatment and/or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological biomechanical process of the human body.

Evaluation of current nutritional status may employ various techniques including, but not limited to, symptom surveys, physical exam, case history, and reflex muscle testing. These methods of evaluation are not intended to diagnose or rule out any disease or condition but merely to analyze the body's nutritional status.

By signing below, I agree that I have read and understand the above statements and agree to the above named procedures. I intend for this consent form to cover this visit and any future visits for which I present.

Unopened supplements must be returned within 30 days of purchase date in good condition with a current expiration date in order to be considered for a refund.

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

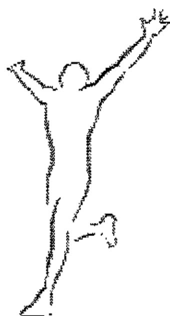
Patient's Signature Date

Name of Patient

Witness Signature Date

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