

**CONFIDENTIAL CASE HISTORY**

# \_\_\_\_\_  
C W P I M

Name \_\_\_\_\_ Email \_\_\_\_\_  
Address \_\_\_\_\_ Cell Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ - \_\_\_\_\_ SS# \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_  
Marital Status: S M D W Spouse's Name \_\_\_\_\_ Number of Children \_\_\_\_\_  
Your Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_  
What do you expect on your first visit? \_\_\_\_\_

Did your symptoms develop from :  Work Related Injury  Auto Accident  Other Injury  Chronic Problem

Major Complaint: \_\_\_\_\_  
Explain when and how it happened: \_\_\_\_\_

Pain is:  Constant  Comes and Goes  Occasional  
Symptoms have persisted for:  Hours  One Day  Days  Months  \_\_\_\_ Years  
Is your condition getting progressively worse?  Yes  No  
Is your condition/pain worse?  In the morning  As the day goes on  
How would you rate your general health?  Excellent  Good  Fair  Poor  
How long has it been since you felt really good? \_\_\_\_\_

Other doctor(s) seen for this condition:  
Name \_\_\_\_\_ Diagnosis \_\_\_\_\_  
Name \_\_\_\_\_ Diagnosis \_\_\_\_\_

Have you had spinal x-rays taken within the last two years?  No  Yes  
Have you had any surgery?  No  Yes  
If yes please explain: \_\_\_\_\_

Have you had any major illnesses/diseases?  No  Yes  
If yes please explain: \_\_\_\_\_

List and explain any injuries, accidents or traumas you've experienced: \_\_\_\_\_

List all medications and or vitamin supplements you take: \_\_\_\_\_

I sleep on my  back  side  stomach on \_\_\_\_\_ pillow(s)

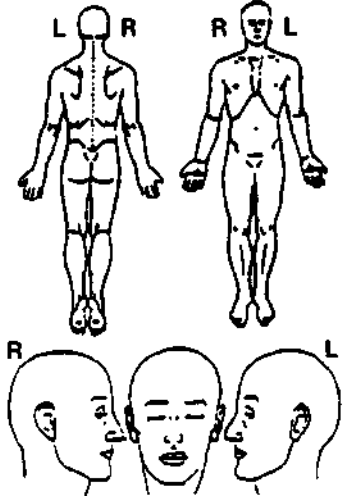
Our office policy requires payment in full for all services rendered at the time of your visit, unless other arrangements have been made. I understand and agree that health and accident policies are an arrangement between an insurance company and myself. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment.

I will be paying today by  Cash  Check  Visa  Mastercard

Signature of responsible Person \_\_\_\_\_  
Date \_\_\_\_\_

Thank you!

Please mark the location of your pain on these figures



**IMPORTANT: PLEASE**

**✓CHECK**

**ALL PRESENT SYMPTOMS**

**HEAD**

- Headache
- Loss of balance
- Dizziness
- Loss of hearing
- Ringing in ears
- Difficulty chewing
- Clicking in jaw  R  L

**NECK**

- Neck pain
- Neck stiffness
- Neck pain with movement
- Neck feels out of place
- Muscle spasms in neck
- Grinding sounds in neck

**SHOULDERS**

- Pain in shoulder joint  R  L
- Pain across shoulders/upper back
- Can't raise arm:  R  L
  - above shoulder level
  - over head

**ARMS & HANDS**

- Pain in upper arm  R  L
- Pain in elbow  R  L
- Pain in forearm  R  L
- Pain in hand  R  L
- Pain in fingers  R  L
- Pain in wrist  R  L
- Numbness in arm  R  L
- Numbness in fingers  R  L
- Cold hands  R  L
- Swollen joints in fingers  R  L
- Sore joints in fingers  R  L
- Loss of grip strength  R  L

**CHEST**

- Chest pain
- Shortness of breath
- Pain around ribs
- Tightness in chest
- Irregular heartbeat

**ABDOMEN**

- Abdominal pain
- Indigestion
- Nausea
- Belching
- Gas
- Constipation
- Diarrhea

- Hemorrhoids

**MID BACK**

- Mid-back pain
- Muscle spasms
- Pain in kidney area

**LOW BACK**

- Low back pain
- Low back pain aggravated by:
  - lifting
  - stooping
  - standing
  - sitting
  - bending
  - coughing
  - lying down (sleeping)
  - sexual activity
  - walking
  - riding in car

**HIPS, LEGS & FEET**

- Pain in buttocks  R  L
- Pain in hip  R  L
- Pain down leg  R  L
- Leg Cramps  R  L
- Cramps in feet  R  L
- Numbness in leg  R  L
- Numbness in feet  R  L
- Numbness in toes  R  L
- Swollen ankles  R  L
- Swollen feet  R  L
- Are you wearing:
  - Heel lifts
  - Sole lifts
  - Orthotics
  - Arch supports

**WOMEN ONLY**

- Abortions
- Hysterectomy
- Genital Cancer
- Fibroid tumors
- Yeast infections
- Premenstrual Syndrome
- Menstruation pain
- Irregularity, Cycle = \_\_\_\_\_ days
- Menopause
- Hot flashes
- Night sweats
- Memory loss
- Breast pain
  - lumps
  - swelling
- Breast Cancer
- Increased sex drive
- Decreased sex drive

- Vaginal discharge
- Birth control pills
- Pregnant
- Nursing

**MEN ONLY**

- Difficult urination
- Frequent urination
- Night urination
- Prostate pain/swelling
- Increased sex drive
- Decreased sex drive

**GENERAL**

- Fever
- Fatigue
- Generally feel run-down
- Excess perspiration
- Dental
  - Metal Fillings
  - Crowns  How many?\_\_
  - Root Canal  How many?\_\_
- Difficulty walking
- Difficulty sleeping
- Loss of sleep \_\_\_\_\_ hrs. per night
- Weight gain \_\_\_\_\_ lbs.
- Weight loss \_\_\_\_\_ lbs.
- Addictions \_\_\_\_\_
- Coffee \_\_\_\_\_ cups/day
- Cola \_\_\_\_\_ cups/day
- Tea \_\_\_\_\_ cups/day
- Cigarettes \_\_\_\_\_ daily/how long \_\_\_\_\_
- Alcohol \_\_\_\_\_ daily
- Recurrent Infections
- Allergies \_\_\_\_\_

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- Appetite - poor/excess
- Psychiatric care
- Anxiety
- Nervousness
- Irritability
- Tension
- Depression
- Mental confusion
- Poor memory
- Memory loss - short term
- Memory loss - long term
- Mood swings
- Nervous stomach
- Phobias
- Frequent sighing
- Tightness/tension in shoulders
- Other \_\_\_\_\_

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# BIOCHEMICAL SURVEY

Name \_\_\_\_\_ Date \_\_\_\_\_

**Check first box for anything you are currently experiencing. Check second box for anything you have ever experienced.**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> <input type="checkbox"/> Abnormal hair growth       | <input type="checkbox"/> <input type="checkbox"/> Eating disorder           | <input type="checkbox"/> <input type="checkbox"/> Metallic taste          |
| <input type="checkbox"/> <input type="checkbox"/> Acid foods upset           | <input type="checkbox"/> <input type="checkbox"/> Eczema                    | <input type="checkbox"/> <input type="checkbox"/> Migrating pains         |
| <input type="checkbox"/> <input type="checkbox"/> Acne                       | <input type="checkbox"/> <input type="checkbox"/> Edema (fluid retention)   | <input type="checkbox"/> <input type="checkbox"/> Milk causes discomfort  |
| <input type="checkbox"/> <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> <input type="checkbox"/> Excess thirst             | <input type="checkbox"/> <input type="checkbox"/> Mucous production       |
| <input type="checkbox"/> <input type="checkbox"/> Addiction - Smoke          | <input type="checkbox"/> <input type="checkbox"/> Eyelids puffy             | <input type="checkbox"/> <input type="checkbox"/> Muscle cramps at night  |
| <input type="checkbox"/> <input type="checkbox"/> Addiction - Sugar          | <input type="checkbox"/> <input type="checkbox"/> Eyes watery               | <input type="checkbox"/> <input type="checkbox"/> Nasal polyps            |
| <input type="checkbox"/> <input type="checkbox"/> Addiction - alcohol        | <input type="checkbox"/> <input type="checkbox"/> Eyes itch                 | <input type="checkbox"/> <input type="checkbox"/> Nausea                  |
| <input type="checkbox"/> <input type="checkbox"/> Addiction - drugs          | <input type="checkbox"/> <input type="checkbox"/> Fainting spells           | <input type="checkbox"/> <input type="checkbox"/> Nervous stomach         |
| <input type="checkbox"/> <input type="checkbox"/> Allergy to drugs           | <input type="checkbox"/> <input type="checkbox"/> Fatigue                   | <input type="checkbox"/> <input type="checkbox"/> Night sweats            |
| <input type="checkbox"/> <input type="checkbox"/> Allergies                  | <input type="checkbox"/> <input type="checkbox"/> Feel cold often           | <input type="checkbox"/> <input type="checkbox"/> Nose bleeds             |
| <input type="checkbox"/> <input type="checkbox"/> Amnesia - temporary        | <input type="checkbox"/> <input type="checkbox"/> Fever                     | <input type="checkbox"/> <input type="checkbox"/> Ovarian cysts           |
| <input type="checkbox"/> <input type="checkbox"/> Anemia                     | <input type="checkbox"/> <input type="checkbox"/> Frequent rashes           | <input type="checkbox"/> <input type="checkbox"/> Pain – unexplained      |
| <input type="checkbox"/> <input type="checkbox"/> Appetite - excess          | <input type="checkbox"/> <input type="checkbox"/> Fungus                    | <input type="checkbox"/> <input type="checkbox"/> Perspiration excess     |
| <input type="checkbox"/> <input type="checkbox"/> Appetite - poor            | <input type="checkbox"/> <input type="checkbox"/> Gallstones                | <input type="checkbox"/> <input type="checkbox"/> PMS                     |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis                  | <input type="checkbox"/> <input type="checkbox"/> Gas                       | <input type="checkbox"/> <input type="checkbox"/> Poor Memory             |
| <input type="checkbox"/> <input type="checkbox"/> Asthma                     | <input type="checkbox"/> <input type="checkbox"/> General itching           | <input type="checkbox"/> <input type="checkbox"/> Post nasal drip         |
| <input type="checkbox"/> <input type="checkbox"/> Bad breath                 | <input type="checkbox"/> <input type="checkbox"/> Greasy foods upset        | <input type="checkbox"/> <input type="checkbox"/> Premature graying       |
| <input type="checkbox"/> <input type="checkbox"/> Belching                   | <input type="checkbox"/> <input type="checkbox"/> Hair loss                 | <input type="checkbox"/> <input type="checkbox"/> Psoriasis               |
| <input type="checkbox"/> <input type="checkbox"/> Bowel disorders            | <input type="checkbox"/> <input type="checkbox"/> Hay fever                 | <input type="checkbox"/> <input type="checkbox"/> Red eyes                |
| <input type="checkbox"/> <input type="checkbox"/> Brain fog                  | <input type="checkbox"/> <input type="checkbox"/> Headache/sinus            | <input type="checkbox"/> <input type="checkbox"/> Ring worm               |
| <input type="checkbox"/> <input type="checkbox"/> Bronchitis                 | <input type="checkbox"/> <input type="checkbox"/> Headache/morning          | <input type="checkbox"/> <input type="checkbox"/> Seizures                |
| <input type="checkbox"/> <input type="checkbox"/> Brown spots                | <input type="checkbox"/> <input type="checkbox"/> Headache/afternoon        | <input type="checkbox"/> <input type="checkbox"/> Sensitive to cold       |
| <input type="checkbox"/> <input type="checkbox"/> Bruise easily              | <input type="checkbox"/> <input type="checkbox"/> Headache/migraine         | <input type="checkbox"/> <input type="checkbox"/> Sinusitis               |
| <input type="checkbox"/> <input type="checkbox"/> Burning/itching anus       | <input type="checkbox"/> <input type="checkbox"/> Hearing decreased         | <input type="checkbox"/> <input type="checkbox"/> Skin problems           |
| <input type="checkbox"/> <input type="checkbox"/> Burning feet               | <input type="checkbox"/> <input type="checkbox"/> Heartburn                 | <input type="checkbox"/> <input type="checkbox"/> Skin peels              |
| <input type="checkbox"/> <input type="checkbox"/> Coated tongue              | <input type="checkbox"/> <input type="checkbox"/> Heart irregularities      | <input type="checkbox"/> <input type="checkbox"/> Sleepy during day       |
| <input type="checkbox"/> <input type="checkbox"/> Cold hands                 | <input type="checkbox"/> <input type="checkbox"/> Hemorrhoids               | <input type="checkbox"/> <input type="checkbox"/> Slow pulse              |
| <input type="checkbox"/> <input type="checkbox"/> Cold feet                  | <input type="checkbox"/> <input type="checkbox"/> Herpes                    | <input type="checkbox"/> <input type="checkbox"/> Smell decreased         |
| <input type="checkbox"/> <input type="checkbox"/> Cold sweats often          | <input type="checkbox"/> <input type="checkbox"/> High altitude problems    | <input type="checkbox"/> <input type="checkbox"/> Sneezing attacks        |
| <input type="checkbox"/> <input type="checkbox"/> Colds/flu frequently       | <input type="checkbox"/> <input type="checkbox"/> High blood pressure       | <input type="checkbox"/> <input type="checkbox"/> Sore throat             |
| <input type="checkbox"/> <input type="checkbox"/> Colitis                    | <input type="checkbox"/> <input type="checkbox"/> Hives                     | <input type="checkbox"/> <input type="checkbox"/> Startles easily         |
| <input type="checkbox"/> <input type="checkbox"/> Constipation               | <input type="checkbox"/> <input type="checkbox"/> Hoarseness                | <input type="checkbox"/> <input type="checkbox"/> Strong light irritates  |
| <input type="checkbox"/> <input type="checkbox"/> Cough                      | <input type="checkbox"/> <input type="checkbox"/> Hot flashes               | <input type="checkbox"/> <input type="checkbox"/> Swollen ankles/feet     |
| <input type="checkbox"/> <input type="checkbox"/> Crave spices               | <input type="checkbox"/> <input type="checkbox"/> Humidity discomfort       | <input type="checkbox"/> <input type="checkbox"/> Thickening skin         |
| <input type="checkbox"/> <input type="checkbox"/> Crave salts                | <input type="checkbox"/> <input type="checkbox"/> Hungry between meals      | <input type="checkbox"/> <input type="checkbox"/> Thinning skin           |
| <input type="checkbox"/> <input type="checkbox"/> Crave sour                 | <input type="checkbox"/> <input type="checkbox"/> Hyperactivity             | <input type="checkbox"/> <input type="checkbox"/> Throat constriction     |
| <input type="checkbox"/> <input type="checkbox"/> Crave onions/beans         | <input type="checkbox"/> <input type="checkbox"/> Ileocaecal Valve Syndrome | <input type="checkbox"/> <input type="checkbox"/> Tingling sensation      |
| <input type="checkbox"/> <input type="checkbox"/> Crave bitters              | <input type="checkbox"/> <input type="checkbox"/> Impotency Syndrome        | <input type="checkbox"/> <input type="checkbox"/> Tires easily            |
| <input type="checkbox"/> <input type="checkbox"/> Crave sweets               | <input type="checkbox"/> <input type="checkbox"/> Indigestion               | <input type="checkbox"/> <input type="checkbox"/> Urinary tract disorders |
| <input type="checkbox"/> <input type="checkbox"/> Cuts heal slowly           | <input type="checkbox"/> <input type="checkbox"/> Infections (Frequent)     | <input type="checkbox"/> <input type="checkbox"/> Urine amount increased  |
| <input type="checkbox"/> <input type="checkbox"/> Dandruff                   | <input type="checkbox"/> <input type="checkbox"/> Insomnia                  | <input type="checkbox"/> <input type="checkbox"/> Urine amount decreased  |
| <input type="checkbox"/> <input type="checkbox"/> Depression                 | <input type="checkbox"/> <input type="checkbox"/> Internal trembling        | <input type="checkbox"/> <input type="checkbox"/> Varicose veins          |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> <input type="checkbox"/> Irritable Bowel Syndrome  | <input type="checkbox"/> <input type="checkbox"/> Warts                   |
| <input type="checkbox"/> <input type="checkbox"/> Diarrhea                   | <input type="checkbox"/> <input type="checkbox"/> Irritable/restless        | <input type="checkbox"/> <input type="checkbox"/> Weight loss             |
| <input type="checkbox"/> <input type="checkbox"/> Difficulty swallowing      | <input type="checkbox"/> <input type="checkbox"/> Labored breathing         | <input type="checkbox"/> <input type="checkbox"/> _____                   |
| <input type="checkbox"/> <input type="checkbox"/> Diverticulitis             | <input type="checkbox"/> <input type="checkbox"/> Loss of taste             | <input type="checkbox"/> <input type="checkbox"/> _____                   |
| <input type="checkbox"/> <input type="checkbox"/> Dry nose                   | <input type="checkbox"/> <input type="checkbox"/> Low blood pressure        | <input type="checkbox"/> <input type="checkbox"/> _____                   |
| <input type="checkbox"/> <input type="checkbox"/> Dry eyes                   | <input type="checkbox"/> <input type="checkbox"/> Lump in the throat        | <input type="checkbox"/> <input type="checkbox"/> _____                   |
| <input type="checkbox"/> <input type="checkbox"/> Dry mouth                  | <input type="checkbox"/> <input type="checkbox"/> Menses, scanty            | <input type="checkbox"/> <input type="checkbox"/> _____                   |
| <input type="checkbox"/> <input type="checkbox"/> Dyslexia                   | <input type="checkbox"/> <input type="checkbox"/> Menses, irregular         |   |
| <input type="checkbox"/> <input type="checkbox"/> Earaches                   | <input type="checkbox"/> <input type="checkbox"/> Menses, excess            |   |
| <input type="checkbox"/> <input type="checkbox"/> Ear infection              | <input type="checkbox"/> <input type="checkbox"/> Menses, painful           |   |

# WEISS HOLISTIC HEALTH CENTER

## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Weiss Holistic Health Center (WHHC) is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

### **Disclosure of Your Health Care Information**

#### **Treatment**

On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with WHHC.

It is our policy to provide a substitute health care provider, authorized by WHHC to provide assessment and/or treatment to our patients, without advanced notice, in the event of Dr. Weiss's absence due to vacation, sickness, or other emergency situation.

#### **Payment**

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

#### **Emergencies**

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

#### **Public Health**

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

#### **Judicial and Administrative Proceedings.**

We may disclose your health information in the course of any administrative or judicial proceeding.

#### **Law Enforcement.**

We may disclose your health information to a law-enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

#### **Deceased Persons.**

We may disclose your health information to coroners or medical examiners.

#### **Organ Donation.**

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

#### **Research.**

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

#### **Public Safety.**

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

#### **Specialized Government Agencies.**

We may disclose your health information for military, national security, prisoner and government benefits purposes.

#### **Marketing.**

We may contact you for marketing purposes or fundraising purposes. It is our practice to participate in charitable events to raise awareness, food or toy donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of WHHC sponsored fund-raising events.

**Appointment Confirmation.**

On occasion, we may call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.

**Change of Ownership.**

In the event that WHHC is sold or merged with another organization, your health information/record will become the property of the new owner.

**Your Health Information Rights**

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that WHHC is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that WHHC amend your protected health information. Please be advised, however, that WHHC is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by WHHC.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

**Changes to this Notice of Privacy Practices**

WHHC reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, WHHC is required by law to comply with this Notice. WHHC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Privacy Officer by calling this office at 215-887-7100. If the Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

**Complaints**

Complaints about your Privacy rights, or how WHHC has handled your health information should be directed to the Privacy Officer by calling this office at 215-887-7100. If the Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights, 200 Independence Avenue, S.W., Room 509F HHH Building, Washington, DC 20201

This notice is effective as of \_\_\_\_/\_\_\_\_/\_\_\_\_. I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide WHHC with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

\_\_\_\_\_  
Patient's Name (print)

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Facility Signature

\_\_\_\_\_  
Date

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

## WEISS HOLISTIC HEALTH CENTER

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of **Weiss Holistic Health Center's** "NOTICE OF PRIVACY PRACTICES," revision date April 14, 2003.

As required by the Privacy Regulations, \_\_\_\_\_ from **Weiss Holistic Health Center** has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.  
*Name of Staff Member*

As required by the Privacy Regulations, I am aware that **Weiss Holistic Health Center** has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

### Requests:

- I wish to file a "Request for Restriction" of my Protected Health Information.
- I wish to file a "Request for Alternative Communications" of my Protected Health information.
- I wish to object to the following in the "Notice of Privacy Practices:"

\_\_\_\_\_  
\_\_\_\_\_

**I understand that this office is not required to honor any changes to the "Notice of Privacy Practices."**

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Print Name

### (OFFICE USE ONLY)

Signed form received by: \_\_\_\_\_ Date: \_\_\_\_\_

Good faith effort to obtain receipt:  
(Describe) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Dr. Don M. Weiss

## **Informed Consent Agreement**

*NMT- The Feinberg Technique Treatment Consent Form*

NeuroModulation Technique (“NMT”) is intended to determine the patient’s perception of conditions contributing to illness. I desire to be screened with NMT, and hereby consent to participate in this type of screening and treatment.

The procedure has been explained to me, and I understand that certain adverse effects may result from the treatment. These could include, but are not limited to, a temporary soreness in muscles of the arms tested, or a temporary flare-up of my symptoms. Other possible side effects include symptoms of heightened immune function or detoxification such as fever, chills, headache or body aches.

I understand that NMT- *The Feinberg Technique* is not a medical diagnostic procedure, and therefore does not diagnose disease. Diagnosis requires particular types of clinical examination procedures by a physician trained in diagnosis. By contrast, NMT is intended to determine the patient’s perception of conditions contributing to illness. I understand that Muscle Response Testing, (“MRT”) employed in NMT, like any medical testing procedure, is not 100% accurate.

I understand that alternative methods of treatment are available. These have been described to me. If I am suffering from severe allergenic reactions to substances, I will consult an appropriate physician and, if so advised, take medication (to prevent itching, tissue swelling, fever, cough, pains, etc.) to keep my symptoms under control while I am being treated with NMT- The Feinberg Technique.

I understand that determination of the existence and identification of particular infectious agents in the body requires specific laboratory testing. NMT- The Feinberg Technique does not diagnose any infectious agent, nor is it a substitute for appropriate laboratory testing. Rather, NMT evaluates the perceptions of the autonomic control system, and immune system with regard to such issues, and attempts to optimize autonomic function with respect to immune system control.

NMT- The Feinberg Technique is not a method of diagnosing or treating cancer. Medical oncologists are the only health care personnel appropriately trained to manage the treatment of cancer. NMT is not a substitute for appropriate medical care of cancer.

I agree to cooperate and take an active role in my treatment by maintaining a positive attitude regarding treatment, continuing contact with and treatment from medical practitioners, and communicating progress and side effects to the health care provider administering NMT. I understand that I am to continue all medication and other treatment modalities as they have been prescribed unless otherwise directed by the doctor who prescribed them.

I understand that there is no guarantee concerning the effect of the treatment. I understand that I am free to discontinue treatment at any time, but acknowledge that I am responsible for full payment of the normal and necessary fees associated with my screening and treatment.

I also understand that clinical data is presently being collected on the technique that requires the gathering of certain information in accordance with research protocols. I understand that the results of this study may be published in a medical or scientific journal, and that a number or letter designating my case, but not my name, may be used in reports of this study.

I have read, or have had read to me, the above statements, and have been provided with the opportunity to ask any pertinent questions I have regarding this screening and treatment program. I have been informed that I am to contact the doctor if any problems are encountered during my treatment. I understand the conditions stated above, and hereby consent to participate in this type of screening and treatment. By signing below I agree to the terms and procedures set forth above.

IN WITNESS WHEREOF, I have executed the foregoing this \_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
*Patient's Signature*

\_\_\_\_\_  
*Patient's Printed Name*

\_\_\_\_\_  
*If minor, signature of parent or guardian*

\_\_\_\_\_  
*Parent or Guardian's Printed Name*

\_\_\_\_\_  
*Practitioner*

\_\_\_\_\_  
*Witness*





## Informed Consent Agreement

### NMT- The Feinberg Technique Remote Treatment Consent Form

Neuro Modulation Technique (“NMT”) is intended to determine the patient’s perception of conditions contributing to illness. I desire to be screened with NMT, and hereby consent to participate in this type of screening and treatment. In this case, I am seeking NMT screening and treatment via telephone as I am unable to physically visit the physicians clinic.

The procedure has been explained to me, and I understand that certain adverse effects may result from the treatment. These could include, but are not limited to, a temporary flare-up of my symptoms. Other possible side effects include symptoms of heightened immune function or detoxification such as fever, chills, headache or body aches. I understand that if any unexpected exacerbation of my symptoms should occur, I am solely responsible for obtaining appropriate medical care to address those symptoms or conditions.

I understand that NMT: The Feinberg Technique is not a medical diagnostic procedure, and therefore does not diagnose disease. Diagnosis requires particular types of clinical examination procedures by a physician trained in diagnosis. By contrast, NMT is intended to determine the patient’s perception of conditions contributing to illness. I understand that Muscle Response Testing, (“MRT”) employed in NMT, like any medical testing procedure, is not 100% accurate. Since I have chosen to undergo screening and treatment via telephone, I understand that my treatment will be based upon surrogate muscle response testing as an indicator of response to semantic queries and statements the practitioner verbally delivers to me. I understand that the efficacy of such treatment has been both established and refuted in published scientific literature.

I understand that alternative methods of treatment are available. These have been described to me. If I am suffering from severe allergenic reactions to substances, or any health condition for which I have been prescribed medications to control dangerous symptoms, I will consult an appropriate physician and, if so advised, take medication (to prevent itching, tissue swelling, fever, cough, pains, etc.) to keep my symptoms under control while I am being treated with NMT: The Feinberg Technique.

I understand that determination of the existence and identification of particular infectious agents in the body requires specific laboratory testing. NMT: The Feinberg Technique does not diagnose any infectious agent, nor is it a substitute for appropriate laboratory testing. Rather, NMT evaluates the perceptions of the autonomic control system, and immune system with regard to such issues, and attempts to optimize autonomic function with respect to immune system control.

Please initial after reading this page. \_\_\_\_\_

NMT: The Feinberg Technique is not a method of diagnosing or treating cancer. Medical oncologists are the only health care personnel appropriately trained to manage the treatment of cancer. NMT is not a substitute for appropriate medical care of cancer, or any other health care condition. I understand that I am not being asked to discontinue any concurrent medical care. Moreover, I understand that it is recommended that I do not discontinue any care prescribed by my doctors.

I agree to cooperate and take an active role in my treatment by maintaining a positive attitude regarding treatment, continuing contact with and treatment from my other health care practitioners, and communicating progress and any possible side effects or new symptoms that may or may not be related to my NMT treatment to the health care provide administering NMT.

I understand that I am to continue all medication and other treatment modalities as they have been prescribed unless otherwise directed by the doctor who prescribed them. I also understand that improvement in my health resulting from the NMT treatment I am requesting, may result in a change in my requirement for medications other providers have prescribed for me, and will consult that medical provider to see if a change in medication or medication dosage is necessary.

I understand that there is no guarantee concerning the effect of the treatment. I understand that I am free to discontinue treatment at any time, but acknowledge that I am responsible for full payment of the normal and necessary fees associated with my screening and treatment. I understand that if I terminate treatment without the recommendation of my NMT practitioner, that this may adversely influence the degree or durability of improvement from my treatment. I agree that if I am being treated for allergies causing dangerous symptoms such as anaphylactic response, or for any condition that is aggravated by certain activities or exposures, that I will not expose myself to such risk of aggravation except as advised by my NMT practitioner under controlled and defined circumstances. I understand that if I expose myself to such aggravating factors prematurely, this may pose a risk to my health.

I understand that any services that are being provided on a remote basis are my sole financial responsibility, and that no aspect of such services may be billed to insurance companies for the purposes of reimbursement. I understand and authorize all charges for this service to be billed to the credit card account I have provided.

I further agree to be interviewed during this teleconference, and that this interview and my voice may be audio taped. I understand that these recorded audiotapes may be used for telephone consultation evaluation, research and NMT encounter purposes only, at both the transmitting and receiving facilities, and that my identity will not be disclosed except where medically necessary. I understand that without prior written consent, said recorded tapes will not be broadcast or otherwise played outside the health care or educational setting.

Please initial after reading this page. \_\_\_\_\_

I also understand that clinical data is presently being collected on NMT that requires the gathering of certain information in accordance with research protocols. I understand that the results of this study may be published in a medical or scientific journal, and that a number or letter designating my case, but not my name, may be used in reports of this study.

I have read, or have had read to me, the above statements, and have been provided with the opportunity to ask any pertinent questions I have regarding this screening and treatment program. I have been informed that I am to contact the doctor if any problems are encountered during my treatment. I understand the conditions stated above, and hereby consent to participate in this type of screening and treatment. By signing below I agree to the terms and procedures set forth above.

IN WITNESS WHEREOF, I have executed the foregoing this \_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Patient's Signature                      Patient's Printed Name

\_\_\_\_\_  
If minor, signature of parent or guardian    Parent or Guardian's Printed Name

\_\_\_\_\_  
Practitioner                                      Witness