Advanced Natural Healthcare and Genetics
A N H C G

John C. Thomas, DNM, DC, CTN, CNS, CFMP, CHHP

Improving Lives through Nutritional Therapies

Welcome to Our Wellness Center

Thank you for choosing our office and allowing us to help you in this time of need. We help sick people get healthy and healthy people stay that way. Our purpose is to help as many people as possible and it is an honor each time we are asked to improve a person's health and we take our role as your healthcare provider very seriously. Our patients' confidence in us drives our commitment to provide the highest quality care possible to them and their families.

We have helped many types of patients with many different symptoms and levels of health. We help our patients to find answers to their health problems and if you are accepted as a patient, we hope to do the same for you. The process of identifying the exact, correct underlying CAUSE of your problems requires a great deal of information and testing.

That process begins with filling out our New Patient Application. **Please take your time and fill this form out completely and thoughtfully**. The doctor will meet with you to discuss your condition. Based on what the doctor learns, special tests may be ordered like x-rays, MRI's, comprehensive genetic analysis or advanced metabolic tests. The doctor will review the information learned from the consultation, examination and prior testing to determine if you are accepted into our office. Everything will be explained to you on at your visit.

We do not accept all cases. If we feel we can help you, we will explain your treatment options. If we feel we cannot, we will help you find someone who can. Again, we look forward to serving you. If you have any questions, please do not hesitate to ask.

IMPORTANT!

Please have the New Patient Application Form completed <u>BEFORE</u> your initial visit. If possible, please submit all paperwork and previous lab testing (past 6-12 months) prior to your initial visit. This allows the doctor to familiarize themselves with your case and do any needed research before your visit. Please submit via:

1) Fax: (770) 627-5309
2) Email: info@anhcg.com
3) Mail (if there is sufficient time):

Advanced Natural Healthcare & Genetics
2230 Towne Lake Parkway, Building 1000-120, Woodstock, Georgia 30189

Confiming Your Appointment

We will call you to confirm your appointment one business day prior to the appointment. If we fail to reach you, please leave a message at (678) 324-6963 or email us confirming the appointment at **info@anhcg.com.** Your initial visit will take about an hour. Please arrive a little early, as our schedule often won't allow us to start an appointment late.

If you would like your appointment to be moved to an earlier date, let us know and we will call you if there is an opening.

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Before Receiving Consultation or Treatment In Our Office
Please Review These Principles Outlined Below

1. Dr. John C. Thomas' goal is to provide you with adjunctive and supportive care for your health condition. We do not claim to treat or cure any disease or medical diagnosis.

2. Our office offers some services that are not covered by insurance. These services are considered experimental and may not be billed to your insurance. Dr. John C. Thomas will review all services that are considered covered services and those that are not.

3. Nutritional support may be offered for your case. Nutritional supplements are not FDA regulated and have not been proven to cure or treat any disease or illness. If Dr. John C. Thomas recommends supplementation in your case you may use the products we have in our office or you may purchase your supplementation elsewhere.

4. Our services are not a replacement for your medical treatment. We choose to work alongside your medical provider as this serves you in the most effective manner possible.

5. Dr. John C. Thomas will never give advice on the use of your medications. Medications must be managed by your medical doctor. You must work with a medical doctor for the management of any medications you take now or in the future.

6. I completely understand that there are no guarantees of help, correction, relief, or cure, written, spoken, or implied. I understand that this clinic does NOT treat any disease or any medical diagnosis.

7. I am making a sane and conscious decision to seek advice as per the above understood terms for either myself and/or my dependents. In doing so, I agree to the above terms and acknowledge this with my signature below.

Patient Signature: _____ Date: _____

New Patient Application

Today's Date: _____

Please Print Clearly. Please complete ALL information on this form.

PERSONAL INFORMATION

First Name:_____ **Middle Initial:** _____ **Last Name:** _____

Called (Nick) Name:_____ **Age:** _____ **Birth Date:**_____ **Gender:** ☐ **M** ☐ **F**

Home Address: _____ **City:** _____

State:_____ **Zip:**_____ **Email:**_____ **May we send you our online newsletters?** ☐ Y ☐ N

Home Phone:_____ **Cell Phone:**_____ **Work Phone:** _____

Employer:_____ **Occupation:** _____

Marital Status: ☐ S ☐ M ☐ W ☐ D **# of Children:** _____ **Spouse's Name:** _____

Emergency Contact:_____**Phone:**_____

Primary Physician:_____ **Phone :**_____

How did you hear about us? ☐ Internet/ Google ☐ Facebook/Instagram ☐ Doctor _____
☐ Advertisement in _____ ☐ Family/Friend _____ ☐ Co-Worker _____

HEALTH HISTORY

Please list your 5 major health concerns in order of importance :

Health Concern Description	Approx. Date Began	Complications or Comments	Full Recovery?

List any major illnesses, injuries, and/or surgeries with approximate dates:

Illness, Injury, Surgery Description	Approx. Date Began	Complications or Comments	Full Recovery?

Any Doctor Visits within: ☐ 12 Months; For:_____☐ *I deny any doctor visits*

Office Use Only

_____

_____

_____

_____

PRESENT COMPLAINTS

List the main health complaints you have in order of their importance:

1. Description of your <u>MAIN or WORST</u> health problem: _____

_____

When did your complaint begin?_____ The condition is: ☐ New ☐ Recurring ☐ Exacerbation ☐ Chronic

Describe how your complaint began? _____

How often do you experience your complaint?

☐ Constant (76-100% of day) ☐ Frequent (51-75% of day) ☐ Occasional (24-50% of day) ☐ Intermittent (0-25% of day)

Is your complaint changing? ☐ Getting Better ☐ Getting Worse ☐ Not Changing

Is your complaint worse in the: ☐ Morning ☐ Afternoon ☐ Night ☐ With Activity ☐ All the time ☐ Unpredictable

What activities do you enjoy, but do poorly or not at all due to your complaint? _____

Who have you seen for your current complaint? ☐ Nobody ☐ Medical Doctor ☐ Osteopath ☐ Physical Therapist

☐ Other Chiropractor ☐ Other _____ ☐ Treatment: _____

What have you done to control your symptoms:_____

What are your expectations/goals from care in our office?_____

Please rate the intensity of your symptoms on a scale of 0-10 (0 being no symptoms, 10 being extreme) _____ Current ____ Avg

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2. Description of your <u>SECOND WORST</u> health problem: _____

_____

When did your complaint begin?_____ The condition is: ☐ New ☐ Recurring ☐ Exacerbation ☐ Chronic

Describe how your complaint began? _____

How often do you experience your complaint?

☐ Constant (76-100% of day) ☐ Frequent (51-75% of day) ☐ Occasional (24-50% of day) ☐ Intermittent (0-25% of day)

Is your complaint changing? ☐ Getting Better ☐ Getting Worse ☐ Not Changing

Is your complaint worse in the: ☐ Morning ☐ Afternoon ☐ Night ☐ With Activity ☐ All the time ☐ Unpredictable

What activities do you enjoy, but do poorly or not at all due to your complaint? _____

Who have you seen for your current complaint? ☐ Nobody ☐ Medical Doctor ☐ Osteopath ☐ Physical Therapist

☐ Other Chiropractor ☐ Other _____ ☐ Treatment: _____

What have you done to control your symptoms:_____

Please rate the intensity of your symptoms on a scale of 0-10 (0 being no symptoms, 10 being extreme) _____ Current ____ Avg

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3. Description of your <u>THIRD WORST</u> health problem: _____

_____

When did your complaint begin?_____ The condition is: ☐ New ☐ Recurring ☐ Exacerbation ☐ Chronic

Describe how your complaint began? _____

What have you done to control your symptoms:_____

Please rate the intensity of your symptoms on a scale of 0-10 (0 being no symptoms, 10 being extreme) _____ Current ____ Avg

Office Use Only

_____

_____

GENERAL HEALTH QUESTIONS (*Please answer the following questions?)*

Metabolism

What is your present weight? _____ What is your ideal weight? _____ Are you currently: ☐ Gaining Weight ☐ Losing Weight

Are you losing weight without trying? ☐ No ☐Yes Do you have problems with recurring headaches? ☐ No ☐Yes

Pain

Do you experience pain or stiffness? ☐ Neck ☐Upper back ☐ Low back ☐ Shoulders ☐ Hips ☐ Other _____

Energy & Sleep

Are you experiencing unusual fatigue and loss of energy? ☐ No ☐Yes What time(s) of day are you most tired? _____

Do you have trouble getting to sleep? ☐ No ☐Yes Do you feel groggy and not rested in the morning? ☐ No ☐Yes

Do you wake in the night and have trouble getting back to sleep? ☐ No ☐Yes How many times do you wake up in the night? _____

What time do you usually go to sleep? _____ Number of hours of sleep per night? _____

Does your pain wake you up at night? ☐ No ☐Yes

Mood

Do you get: ☐ Depression ☐ Worry ☐ Lack of Concentration ☐ Memory Problems ☐ Anxiety ☐ Panic Attacks ☐ Other

Do you have irritability or mood swings? ☐ No ☐Yes

Digestion

Do you have or experience? ☐ digestive gas ☐ bloating ☐ constipation ☐ diarrhea ☐ reflux ☐ heartburn

Have you had a change in bowel or bladder habits? ☐ No ☐ Yes

Number of bowel movements: ☐ More than 1/day ☐ 1/day ☐ Every 2 days ☐ 3/week ☐ 2/ week ☐ 1/ week ☐ Other _____

Allergies

Do you have allergy or sinus problems? ☐ No ☐Yes List any food / substances you are sensitive or allergic to: _____

_____

STRESS or MAJOR LIFE CHANGES: (divorce, losses, trauma, job, relocation, major life problems, etc.)

_____

_____

Blood Sugar Levels (if checked)

The HIGHEST your blood sugar gets: WITH medication _____ WITHOUT medication _____

The LOWEST your blood sugar gets: WITH medication _____ WITHOUT medication _____

FAMILY HISTORY

Father: Age:_____ or Age at Death:_____ Cause of Death:_____ Significant Illness:_____

Mother: Age:_____ or Age at Death:_____ Cause of Death:_____ Significant Illness:_____

Are there any diseases or conditions common among your family members? ☐ No ☐ Yes, which relative and what type of condition?

☐ Cancer ☐ Diabetes ☐ Heart ☐ Other _____

Any household pets or other animals you or family members are in close contact with? _____

Do pets have health conditions of any kind? ☐ No ☐ Yes What kind? _____ How many? _____

WOMEN ONLY

OB/GYN ☐ I have never been pregnant ☐ I have been pregnant ☐ I am currently pregnant ☐ I am NOT pregnant

Menstrual: Age of onset_____ Last menses ____/____/____ My menses are Regular / Irregular ☐ I am in menopause

Do you experience cramping? ☐ No ☐ Slight ☐ Moderate ☐ Severe **Do you have PMS symptoms?** ☐ No ☐ Yes

Is so, what? ☐ Bloating ☐ Cravings ☐ Back Pain ☐ Irritable ☐ Moody ☐ Other _____

Birth Control Pill Information: Have you ever used Hormonal-type Birth Control? (Pills, Patch, Injection, Implant, IUD) ☐No ☐Yes

Are you currently on Birth Control? ☐ No ☐ Yes Total years on Birth Control? _____ Stopped _____ years ago

I was originally on Birth Control for: ☐ Birth Control ☐ PMS / Irregular Cycle / Other Problem (Fibroids, Endometriosis, etc.)

HEALTH HISTORY (*Please check the correct box for each item below. Check at least one box for each sign or symptom listed)*

Childhood Illness: ☐ *I deny any childhood illnesses*
☐ ADD ☐ Allergies ☐ Sickle Cell ☐ Spina Bifida
☐ Bed Wetting ☐ Hay fever ☐ Asthma ☐ Eczema/Rash
☐ Diabetes ☐ Cerebral Palsy ☐ Chicken Pox ☐ Depression
☐ Food Allergies ☐ Ear Infections ☐ Fetal Drug Exposure ☐ HIV
☐ Measles ☐ Headaches ☐ Hepatitis ☐ Scoliosis
☐ Seizure Disorder ☐ Mumps ☐ Mono ☐ Other

Adult Illness: ☐ *I deny any adult illnesses*
☐ Alzheimer's ☐ CRPS(RSD) ☐ Emphysema ☐ Heart Dx ☐ Parkinson's ☐ STD's
☐ Anemia ☐ CVA(stroke) ☐ Eye Problem ☐ Liver Disease ☐ Pleurisy ☐ Ear Infection
☐ Arthritis ☐ Kidney Dx. ☐ Fibromyalgia ☐ Lunge Disease ☐ Pneumonia ☐ Thyroid
☐ Asthma ☐ Depression ☐ HIV ☐ Chron's/Colits ☐ Psychiatric ☐ Vertigo
☐ Cancer ☐ Hypertension ☐ Hepatitis ☐ Shingles ☐ Scoliosis ☐ Chicken Pox
☐ Suicide Attempts ☐ Multiple Sclerosis ☐ Diabetes (insulin / non-insulin) ☐ Lupus (Discoid / Systemic) ☐ Influenza Pneumonia ☐ Similar to current complaints
☐ Seizure Disorder ☐ Epstein Bar
☐ Other_____

Any Injuries: ☐ *I deny any injuries*
☐ Broken Bones ☐ Back Injury ☐ Severe Fall
☐ Head Injury ☐ Disc Injury ☐ Disability
☐ Industrial Accident ☐ Joint Injury ☐ Severe Laceration
☐ Soft Tissue Injury ☐ Motor Vehicle Accident _____

Any Surgeries: ☐ *I deny any surgeries*
☐ Angioplasty ☐ Carpal Tunnel ☐ Dental Surgery ☐ Hysterectomy ☐ Mastectomy ☐ Tonsillectomy
☐ Appendectomy ☐ Coronary Bypass ☐ Gallbladder ☐ D & C ☐ Pacemaker ☐ Other:_____
☐ Caesarean Section ☐ Cosmetic ☐ Hemorroidectomy ☐ Laminectomy ☐ Rotator Cuff
☐ Cardiac Catheterization ☐ Hernia Repair ☐ Joint Reconstruction ☐ Joint Replacement ☐ Spinal Fusion

SOCIAL HISTORY

Educational Level (highest you attained): ☐ Grade School ☐ High School-Graduate ☐ High School-No Degree ☐ High School-GED ☐ College-Graduate ☐ College-No Degree ☐ College-Postgraduate

Exercise: ☐ None ☐ Occasional ☐ Regular ☐ Frequent / Heavy What kind:_____

Substance Usage: Alcohol: ☐ None ☐ Rarely ☐ Occasionally ☐ Heavy ☐Recovering Alcoholic/How long?_____
Types? _____ # ____ how many per: ☐ Day ☐ Week ☐ Month

Recreational Drugs: ☐ None ☐ Past ☐ Type Used: _____ How Often? _____

Tobacco: ☐ None ☐ Cigarettes, packs per day:_____ ☐ Chews, pouches per week:_____
☐ Dip, cans per week:_____ ☐ Previously smoked:_____ years, and quit _____ years ago

Caffeine: ☐ None ☐ Sodas (☐ regular ☐ diet) _____ glasses per: ☐ Day ☐ Week ☐ Month
☐ Coffee ____ cups per: ☐ Day ☐ Week ☐ Month (☐ Sugar ☐ milk ☐ non-dairy creamer)
☐ Tea (☐ sweet ☐ unsweet) _____ glasses per: ☐ Day ☐ Week ☐ Month
☐ Energy Drinks _____ per: ☐ Day ☐ Week ☐ Month

Sweets: ☐ None ☐ Chocolate / Candy _____ times per: ☐ Day ☐ Week ☐ Month

Milk / Dairy: ☐ None ☐ _____ times per: ☐ Day ☐ Week ☐ Month

Wheat Products: ☐ None ☐ _____ times per: ☐ Day ☐ Week ☐ Month (include bread, bagels, pasta, etc.)

Other Grains: ☐ None ☐ _____ times per: ☐ Day ☐ Week ☐ Month (rice, oats, corn, quinoa, etc.)

How Much Water Do You Drink (8 oz. glasses / day): ☐ None ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10-12 ☐ 13-15 ☐ 16+

Hobbies You Enjoy: _____

_____

Hobbies / Activities that are limited or prevented by your current health condition? _____

_____

DIET (*Please fill out your diet for the 3 day, - food and beverage. Please be as detailed as possible.. Identify brands and how it was made. PLEASE BE HONEST.)*

DAY 1

BREAKFAST (Time eaten: _____) _____

_____

LUNCH (Time eaten: _____) _____

_____

DINNER (Time eaten: _____) _____

_____

SNACK (Time eaten: _____) _____

_____

SNACK (Time eaten: _____) _____

_____

DAY 2

BREAKFAST (Time eaten: _____) _____

_____

LUNCH (Time eaten: _____) _____

_____

DINNER (Time eaten: _____) _____

_____

SNACK (Time eaten: _____) _____

_____

SNACK (Time eaten: _____) _____

_____

DAY 3

BREAKFAST (Time eaten: _____) _____

_____

LUNCH (Time eaten: _____) _____

_____

DINNER (Time eaten: _____) _____

_____

SNACK (Time eaten: _____) _____

_____

SNACK (Time eaten: _____) _____

_____

Was the past 3 days of food your typical dietary intake? ☐ No ☐Yes if No explain _____

_____

How many meals do you typically eat per day**?** _____ if not 3 meals per day, which meals do you skip most often? _____

How often do you eat out? ☐ None ☐ _____ times per: ☐ Day ☐ Week ☐ Month Where? _____

List the three worst foods you eat during the week: _____ _____ _____

List the three healthiest foods you eat during the week: _____ _____ _____

DRUGS, MEDICATIONS, SUPPLEMENTS

(*Please list current medications and supplements being taken, include over the counter medication)*

Medications: ☐ None ☐ Allergies ☐ Anti-Depressants ☐ Blood Pressure ☐ Insulin ☐ Muscle Relaxers
☐ Nerve Pills ☐ Pain Killers ☐ Cholesterol ☐ Other: _____

Drug/Supplement Name	Taken for What or Condition?	Taken How Often?	Aprox. Start Date	Results/Side effects experiencing?

Antibiotics: # of antibiotic prescribed or taken in past year: _____ Avg. # prescribed or taken per year for past 5 years: _____

TOXIC EXPOSURE

To your knowledge, have you ever had long-term exposure to chemicals, pesticides, herbicides, radiation, or heavy metals?

☐ No ☐Yes, explain _____

DENTAL WORK

(Please indicate how many of the following you have:)

☐ Silver Fillings # ___ Current / #____Previous ☐ Gold Crowns or inlays ☐ Root Canals _____ ☐ Braces ☐ Bleeding Gums

☐ Composites (tooth-colored) _____ ☐ Stainless steel crowns or inlays _____ ☐ Root Canals with EndoCal _____

☐ Extractions _____ ☐ Porcelain crowns or inlays _____ ☐ Posts _____ ☐ Sensitive Teeth _____

☐ Bridgework _____ ☐ DeGussa Porcelain crowns or inlays _____ ☐ Implants _____ ☐ Bad Bite _____

☐ Partial or Full Dentures _____ ☐ Veneers _____ ☐ Temporaries _____ ☐ New Cavities _____

Have you had any teeth extracted? (wisdom teeth, four bicuspid extraction, etc?) ☐ No ☐Yes _____

Have you had dental surgery? (gum surgery, jaw surgery, etc?) ☐ No ☐Yes_____

Do you need further dental work? ☐ No ☐Yes, if so what?_____

REVIEW OF SYSTEMS *(Please mark ALL boxes that apply.)*

Constitutional: ☐ Chills ☐ Night Sweats ☐ Weight Gain ☐ Weight Loss ☐ Fatigue ☐ Fever ☐ Daytime Drowsiness
☐ *I deny any constitutional issues*

Eye/Vision: ☐ Blindness ☐ Double Vision ☐ Eye Pain ☐ Photophobia ☐ Tearing ☐ Blurry Vision ☐ Cataracts
☐ *I deny any eye/vision issues* ☐ Change in Vision ☐ Glaucoma ☐ Field Cuts ☐ Itchy Eyes ☐ Wear Glasses / Contacts

Ears, Nose and Throat:
☐ *I deny any E/N/T issues*
☐ Bleeding ☐ Fainting ☐ Nasal Congestion ☐ Ear Drainage ☐ Post Nasal Drip ☐ Runny Nose
☐ Discharge ☐ Headaches ☐ Sinus Infections ☐ Ear Infections ☐ Hoarseness ☐ TMJ Problems
☐ Dizziness ☐ Smell Loss ☐ Dental Implants ☐ Hearing Loss ☐ Ear Pain ☐ Snoring
☐ Sore Throats (frequent) ☐ Tinnitus (ringing in ears) ☐ Difficulty Swallowing

Respiration: ☐ Asthma ☐ Coughing up blood ☐ Sputum production ☐ Cough ☐ Shortness of breath ☐ Wheezing
☐ *I deny any respiratory issues*

Cardiovascular:
☐ *I deny any cardiovascular issues*
☐ Angina (chest pain or discomfort) ☐ Heart Murmur ☐ Palpitations (irregular or forceful heart beats)
☐ Claudication (leg pain/achiness) ☐ Heart Problems ☐ Paroxysmal Nocturnal Breathing (waking at night
☐ Swelling of legs ☐ Ulcers with shortness of breath)
☐ Varicose Veins ☐ Orthopnea (difficulty breathing while lying down)

Gastrointestinal:
☐ *I deny any gastrointestinal issues*
☐ Abdominal Pain ☐ Belching ☐ Indigestion ☐ Difficulty Swallowing ☐ Vomiting Blood
☐ Rectal Bleeding ☐ Diarrhea ☐ Jaundice ☐ Abnormal Stool Caliber (quality)
☐ Black/Tarry Stools ☐ Heartburn ☐ Nausea ☐ Abnormal Stool Color
☐ Constipation ☐ Hemorrhoids ☐ Vomiting ☐ Abnormal Stool Consistency

Female:
☐ *I deny any female issues*
☐ Birth Control Therapy ☐ Cramps ☐ Irregular Menstruation ☐ Vaginal Discharge
☐ Breast Lump/Pain ☐ Frequent Urination ☐ Urine Retention
☐ Burning Urination ☐ Hormone Therapy ☐ Vaginal Bleeding

Male:
☐ *I deny any male issues*
☐ Burning Urination ☐ Frequent Urination ☐ Erectile Dysfunction
☐ Prostate Problems ☐ Urination Retention ☐ Hesitancy/Dribbling

Endocrine:
☐ *I deny any endocrine issues*
☐ Cold Intolerance ☐ Excessive Appetite ☐ Excessive Thirst ☐ Goiter ☐ Hair Loss
☐ Voice Change ☐ Excessive Hunger ☐ Frequent Urination ☐ Heat Intolerance ☐ Diabetes
☐ Unusual Hair Growth

Skin:
☐ *I deny any skin issues*
☐ Nail Texture Changes ☐ Hair Loss ☐ Itching ☐ Varicosities ☐ Skin Color Changes
☐ Hair Growth ☐ Hives ☐ Rash ☐ Skin Lesions/Ulcers ☐ History of Skin Disorders
☐ Paresthesia (numbing/prickling/tingling)

Nervous System:
☐ *I deny any nervous system issues*
☐ Dizziness ☐ Limb Weakness ☐ Numbness ☐ Sleep Disturbance ☐ Tremors
☐ Facial Weakness ☐ Loss of Consciousness ☐ Seizures ☐ Strokes
☐ Headaches ☐ Loss of Memory ☐ Stress ☐ Unsteadiness of Gait

Psychological:
☐ *I deny any psychological issues*
☐ Anxiety ☐ Depression ☐ Mood Changes ☐ Convulsions ☐ Appetite Changes
☐ Insomnia ☐ Memory Loss ☐ Confusion ☐ Bipolar Disorder ☐ Other

Allergy: ☐ Anaphylaxis (history of sneezing) ☐ Food Intolerance ☐ Itching ☐ Sneezing ☐ Nasal Congestion
☐ *I deny any allergy issues*

Hematology:
☐ *I deny any hematology issues*
☐ Anemia ☐ Blood Clotting ☐ Bleeding ☐ Fatigue ☐ Bruises Easily
☐ Blood Transfusions ☐ Lymph Node Swelling

Office Use Only

_____

_____

Additional information regarding your health you think we may need to know:

Financial Terms of Acceptance and Consent

I understand this care does not promote or practice medicine, any decisions about medication changes or alterations must be discussed with your medical doctor. Many of the treatments used to help support your condition including functional medicine/genetic evaluations, bioresonance testing, detoxification and nutritional support, brain-based therapies, PEMF, RIFE, infrared light therapy, infrared sauna, oxygen or vibration therapy may not be covered by insurance and may not be reimbursable.

The patient acknowledges and agrees to be responsible to Advanced Natural Healthcare and Genetics, Inc. for any costs incurred in collecting checks that are denied due to insufficient funds, stopped payments, or any other reason. A service charge of $30.00 will be charged for any check upon which payment is denied.

If the patient chooses to finance care through a 3rd party, the patient understands that the financing companies are separate and distinct entities and are not affiliated with Advanced Natural Healthcare and Genetics, Inc. or Dr. John C. Thomas. Therefore, we are not responsible for any dispute between the patient and the financing company.

It is impossible for the doctors to know exactly how many treatments or consultations the patient will need to reach maximum recovery. The support plans recommended above is an approximation and may be adjusted according to patient presentation.

In the event the patient terminates the care prematurely, the patient is responsible for all care they have received at the time of termination minus any discounts offered and will be refunded any pro-rated fees owed based on the current fee schedule. The fee schedule for each service is listed or available by contacting our office. We cannot legally refund any fees for service already performed, even if the patient is not satisfied with the results of the treatment. Refunds are issued within 30 days. Any prepayment of testing and services that are not completed within 6 months of being issued and paid for, will be forfeited unless other arrangements have been made with our office, such as an agreement to pause care due to unforeseen circumstances.

I hereby consent to the performance of consultation, examination, diagnosis, diagnostics, and any treatment listed above, on me (or the patient named above, for whom I am legally responsible) by Dr. John C. Thomas and/or other professionals working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backdrop for Dr. John C. Thomas and Advanced Natural Healthcare and Genetics, Inc. I understand and I am informed that there is the unlikely possibility of adverse events from examination and treatment including, but not limited to, soreness, fractures, disc injuries, strokes, dislocations, sprains, increased symptoms and pain, or no improvement of symptoms or pain. I agree that if I suspect any adverse event that I will inform Dr. Thomas immediately. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatments. I understand that this clinic does not treat disease or any medical diagnosis. I intend this consent form to cover the entire course of treatment of my present condition and for any future condition(s) for which I seek treatment. I understand that I may refuse treatment at any time and that I am responsible for my healthcare choices.

NOTE: Due to the cutting-edge nature of our care, Insurance does not pay for Genetics/Nutrigenomics, Neurological Services, Functional Medicine/Nutrition, bioresonance Testing, most advanced lab testing and therapies. You will have to pay for services in this office. Some major medical insurance may pay for standard lab testing, but more functional tests are falling outside their coverage and are as a result cash-basis. We have contracted with several discount labs which offer a discount off retail test prices as well. Most functional tests, including genetics, salivary tests, stool tests, food antibody tests and immune panels are non-covered and are therefore the responsibility of the patient.

By signing below, I acknowledge that I understand and agree to all terms of acceptance. I also acknowledge that any questions that I have regarding treatment, or my financial obligation, have been met to my satisfaction. I understand that this is a legal and binding document.

TO BE COMPLETED BY THE PATIENT

Printed Name:_____ Signature:_____ Date:_____

TO BE COMPLETED BY THE PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

Patient's Name:_____ Patient's Signature:_____

Date Signed: _____ Signature of Representative:_____

Relationship or Authority of Patient's Representative:_____