

OPRI HEALTH

We are a Private Medical Membership Association. By joining a Private Association, we changed our status from a Public Jurisdiction to a Private one, as in a Private School, a Homeowner's Association, or a Private Country Club. Our 1st and 14th Amendment Association protects your Freedom of Choice and our Right to help You in a Natural way. We are not Open to the General Public and our Members are Informed and Knowledgeable about What we do. Your records and history are never given out without your written permission. You will receive a copy of your Membership Application.

OPRI HEALTH
(A Private Membership Association)
MEMBERSHIP CONTRACT

I, _____, for membership fee paid in hand, do hereby apply for membership in OPRI Health, a private membership organization. With the signing of this membership agreement I/we accept the offer made to become a member of OPRI Health and have read and agree with the following Declaration of Purpose from Article I of OPRI Health's Articles of Association.

1. This Association of members hereby declares that our main objective is to maintain and improve the civil rights, constitutional guarantees, and political freedom of every member and citizen of the United States of America. We believe that the Constitution of the United States is one of the best documents ever devised by man, and the signers of the Declaration of Independence did so out of love for their country.

2. As members, we affirm our belief that the Constitution of the United States is one of the best documents ever devised by man and the signer of the Declaration of Independence did so out of love for their country. We believe that the First Amendment of the Constitution of the United States of America guarantees our members the rights of free speech, petition, assembly, and the right to gather together for the lawful purpose of advising and helping one another in asserting our rights under the Federal and State Constitutions and Statutes. We strive to maintain and improve the civil rights, constitutional guarantees, freedom of choice in health care and political freedom of every member and citizen of the United States of America.

IT IS HEREBY Declared that we are exercising our right of "freedom of association" as guaranteed by the 1st and 14th Amendments of the U.S. Constitution and equivalent provisions of the various State Constitutions. This means that our association activities are restricted to the private domain only.

3. We declare the basic right of all of our members to select spokesmen from our number who could be expected to give wisest counsel and advice concerning the need for physical and mental health care assistance and to select from our number those members who are the most skilled to assist and facilitate the actual performance and delivery of therapy, treatment and care.

4. We proclaim the freedom to choose and perform for ourselves the types of therapies and treatment modalities that we think best for diagnosing, treating and preventing illness and disease of our minds and bodies and for achieving and maintaining optimum wellness. We proclaim and reserve the right to include medical and health options that include but are not limited to cutting edge treatment modalities and therapies practiced or used by any types of healers or therapists or practitioners the world over whether traditional or nontraditional, conventional or unconventional.

5. Specifically, the mission of our Association is to provide members with the highest level of quality care and the most effective methods of treatment. We treat members and their health and medical condition, and not merely the symptoms experienced. Our Association understands that wellness has many dimensions and strives every day to stay on the leading edge of new technology. The Association provides comprehensive, conventional, complementary alternative care and the most advanced technologies to diagnose all aspects of a member's disease and provide the most effective means of treatment at an affordable fee. More specifically, the Association specializes in the services of X-rays, Cold Laser (Class 4 Laser), Spinal Decompression, Hydrotherapy, Intersegmental Therapy, Beam Ray and Nano Therapy, Spinal Alignment, Platelet Rich Plasma Therapy (PRP), Stem Cell Injections, Platelets, and Exosomes. The products that the Association offers are but not limited to: Protein Powder, Colloidal Silver, Greens, Digestive Enzymes, Colon Cleans, Vitamins, Tens Units and Pads, Posture Wedges, and Lifewave Patch Therapy for the benefit to its members.

6. The Association will recognize any person (irrespective of race, color, or religion) who is in accordance with these principles and policies as a member, and will provide a medium through which its individual members may associate for actuating and bringing to fruition the purposes heretofore declared.

MEMORANDUM OF UNDERSTANDING

I understand that the fellow members of the Association that provide services and care, do so in the capacity of a fellow member and not in the capacity as a licensed health care provider. I further understand that within the association no doctor-patient relationship exists but only a contract member-member Association relationship. In addition, I have freely chosen to change my legal status as a public patient or client to a private member of the Association. I further understand that it is entirely my own responsibility to consider the advice and recommendations offered to me by my fellow members and to educate myself as to the efficacy, risks, and desirability of same and the acceptance of the offered or recommended diagnosis, therapy, treatment and care is my own carefully considered decision. Any request by me to a fellow member to assist me or provide me with the aforementioned diagnosis, therapy, treatment and care is my own free decision in an exercise of my rights and made by me for my benefit, and I agree to hold the Trustee(s), staff and other worker members and the Association harmless from any unintentional liability for the results of such care, except for harm that results from instances of a clear and present danger of substantive evil as determined by the Association, as stated and defined by the United States Supreme Court.

The Trustee and members have chosen Andrew Sanders as the person best qualified to perform services to members of the Association and entrust him to select other members to assist him in carrying out that service.

In addition, I understand that since the Association is protected by the First and Fourteenth Amendments to the U.S. Constitution, it is outside the jurisdiction and authority of Federal and State Agencies and Authorities concerning any and all complaints or grievances against the Association, any Trustee(s), members or other staff persons. All rights of complaints or grievances will be settled by an Association Committee and will be waived by the member for the benefit of the Association and its members. Because the privacy and security of membership records maintained within the Association which have been held to be inviolate by the U.S. Supreme Court, the undersigned member waives HIPAA privacy rights and complaint process. Any medical or healthcare records kept by the association will be strictly protected and **only** released upon written request of the member. I agree that violation of any waivers in this membership contract will result in a no contest legal proceeding against me. In addition, the Association does not participate in any medical insurance plans or collections on behalf of the member but will provide a suitable invoice for the member to pursue reimbursement by his/her insurance company, if applicable.

I agree to join the Association, a private membership association under common law, whose members seek to help each other achieve better health and live longer with good quality of life.

I understand that the doctors, nurses, and other providers who are fellow members of the Association are offering me advice, services, and benefits that do not necessarily conform to conventional medical care. I do not expect these benefits to include on-call coverage, hospital care, or the usual and customary care provided by most physicians. I will receive such primary and specialist care elsewhere. I fully understand that the benefits I receive from the Association might or might not be covered by my health insurance and not at all by Medicare.

As a member, I accept the goals of helping my body function better and choosing techniques that are both very safe and have a reasonably good chance to succeed, realizing that no diagnostic technique or treatment is foolproof. If I choose to forgo drugs, surgery, or radiation that has been recommended to me by others, I fully accept the risk that I might suffer serious consequences from that choice. Other aspects of informed consent will take place in my discussions with the providers and my fellow members of the Association.

My activities within the Association are a private matter that I refuse to share with the State Medical Board, the FDA, FTC, Medicare, Medicaid or my own insurance company without my expressed specific permission. All records and documents remain as property of the Association, even if I receive a copy of them. I fully agree not to file a malpractice lawsuit against a fellow member of the Association unless that member has exposed me to a clear and present danger of substantive evil. I acknowledge that the members of the Association do not carry malpractice insurance.

I enter into this agreement of my own free will or on behalf of my dependent without any pressure or promise of cure. I affirm that I do not represent any State or Federal agency whose purpose is to regulate and approve products. I have read and understood this document, and my questions have been answered fully to my satisfaction. I understand that I can withdraw from this agreement and terminate my membership in this association at any time. These pages and Article I of the articles of association of the Association consist of the entire agreement for my membership in the Association and they supersede any previous agreement.

I understand that the membership fee entitles me to receive those benefits declared by the Trustee(s) to be "general benefits" free of further charge. I agree to pay as levied those benefits that I receive that are declared by the Trustees to be "special assessments", per Fee Schedule.

I enclose the sum of \$25.00 as consideration for my one-time lifetime membership contract, said term beginning with the date of the signing of this contract, and by these presents do hereby certify, attest and warrant that I have carefully read the above and foregoing OPRI Health's Contractual Application for Membership and I fully understand and agree with same.

IN WITNESS WHEREOF I set my hand this _____ day of _____, 20____.

Member's Name _____
(Name of legal guardian if Applicant under 18 years, if applicable)

Member's Signature _____
(Signature of legal guardian if Applicant under 18 years, if applicable)

Member's Contact Information:

Street _____ City _____ State _____ Zip Code _____

Home/Work/Cell #s _____ email address _____

OPRI HEALTH

By _____

Approved and accepted this _____ day of _____, 20____.

DISCLAIMER

The information obtained from OPRI Health seminars, lectures, talks, tutorials, demonstrations, and therapeutic sessions, and any of the supporting information provided by OPRI Health as to its services and benefits to its private members, is for educational purposes for members only. Although we have performed extensive training and research regarding these principles, our trustees, officers and supporting staff of OPRI Health are not licensed healthcare or medical providers. Information provided by members of OPRI Health should not be considered a substitute for the advice of a licensed healthcare or medical practitioner in handling your medical needs.

Printed Name

Signature

Date

OPRI Health
A Private Medical Membership Association



OPRI®

**ORGANIC PHARMACY
RESEARCH INSTITUTE**

OPRI HEALTH
2215 G Street
Bakersfield, CA 93301
(661) 324-4431

Date of Initial Visit _____

First Name _____ Last Name _____ MI _____

Address _____ City/State/Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ Email _____

Do we have your permission to communicate with you through Email? Yes No

Birthdate _____ Age _____ Social Security # _____

Sex: M F Marital Status: S M D W Spouse's Name _____

Race: White African American Hispanic Asian Other _____

Your Occupation _____ Your Employer _____

How did you hear about our office: Internet Newspaper Referral Other _____

Name of Primary Care Physician: _____ May we contact? Yes No

Have you seen a Chiropractor before? If yes, when & why? _____

EMERGENCY CONTACT

Name _____ Relation _____

Home Phone _____ Work Phone _____

Cell Phone _____

INSURANCE INFORMATION

Do you have Health Insurance? Yes No

If You are Insured, Please Provide a Copy of Your Insurance Card.

Also, Provide a Copy of Your Driver's License.

REVIEW OF SYSTEMS

- Previously Presently
- GENERAL SYMPTOMS/CONDITIONS**
- _____
- Migraines
- Headaches
- Fainting
- Fatigue
- Loss of Sleep
- Loss of Weight
- Night Sweats
- Anemia
- Diabetes
- Dizziness
- _____ other

- Previously Presently
- GASTRO-INTESTINAL**
- Belching or Gas
- Acid Reflux
- Heart Burn
- Colon Trouble
- Constipation
- Chronic Diarrhea
- Hemorrhoids (piles)
- Diverticulitis
- Liver Trouble
- Chronic Nausea
- Chronic Stomach Pain
- Chronic Vomiting
- Vomiting Blood
- Bloody Stool
- Irritable Bowel
- Ulcers
- Chron's Disease
- _____ other

- CARDIO-VASCULAR**
- High Blood Pressure
- Low Blood Pressure
- Strokes
- Chest Pain
- Heart Trouble
- Irregular Heartbeat
- Poor Circulation
- Swollen Ankles
- Varicose Veins
- Pacemaker
- _____ other

- Previously Presently
- EYE/EAR/NOSE/THROAT**
- Sinusitis
- Deafness
- Chronic Earaches
- Hearing Impairment
- Ringing in Ears
- Frequent Colds
- Chronic Nose Bleeds
- Visual Disturbances
- Floaters
- Corrective Lenses
- Blurred Vision
- Chronic Sore Throats
- Chronic Tonsillitis
- _____ other

- MUSCULOSKELETAL**
- Neck Pain
- Mid Back Pain
- Low Back Pain
- Right Hernia
- Left Hernia
- Painful Tail Bone
- Spinal Curvature
- Shoulder Pain L or R
- Knee Pain L or R
- Leg Pain L or R
- Spinal Disc Disease
- Broken Bones
- Arthritis
- _____ other

- Previously Presently
- GENITO-URINARY**
- Blood in Urine
- Frequent Urination
- Incontinence
- Painful Urination
- Kidney Stones
- Kidney Infections
- Chronic UTI's
- Prostate Problems
- _____ other

- NEUROLOGICAL**
- Anxiety/Nervousness
- Mood Swings
- Phobias
- Mental Disorders
- Multiple Sclerosis
- Epilepsy
- Memory Impairment
- Depression
- Numbness
- Tingling
- _____ other

- REPRODUCTIVE**
- Irregular Cycle
- Hot Flashes
- Hysterectomy
- Sexual Dysfunction
- STD's
- HIV/AIDS
- _____ other

Yes No Pregnant at this time?
 _____ Last Menstrual Cycle

Explain your selections from above including details and year diagnosed: _____

List all MEDICATIONS & SUPPLEMENTS you are taking, the reason you are taking them & the dosage: _____

Family History (parents, siblings, etc.) check all that apply and explain below:

- Cancer If yes, what kind? _____
- Diabetes High Blood Pressure Low Blood Pressure Heart Attack Stroke
- Other: _____
- NONE/NO significant family history to report**

Please explain Details: (i.e. Diabetes/Mother /diagnosed 1985).

Have you been involved in any **Auto Accidents** or other **Trauma**? No Yes

If yes - when and where? _____

Describe: _____

Social History

Do you currently **Smoke**? No Yes If yes, what do you smoke? _____

How long have you **Smoked**? _____ How many per day? _____

Have you **Smoked** previously? No Yes

If yes, what year did you **start** _____? What year did you **quit** _____?

Do you drink **Alcohol**? No Yes If yes, what & how many per day? _____

Do you drink **Caffeine**? No Yes If yes, what & how many per day? _____

Do you **Exercise**? No Yes (what forms and how often): _____

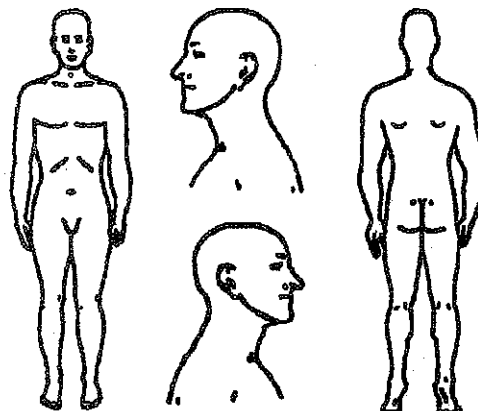
How much **Water** do you drink per day? _____

Allergies: Seasonal Aspirin Dairy Latex Molds Penicillin NONE Other

List any major diagnosis, hospitalizations and/or illnesses: NONE: _____

List all Surgeries and the ~year the surgery was performed (Be Specific – i.e. Right Knee/1998): NONE:

PLEASE MARK YOUR AREAS
OF PAIN ON THE DIAGRAM



COMPLAINT

Please fill out a separate complaint form for each area. For example, if you are having neck and low back pain you will fill out one for neck and one for low back.

What is your Complaint? (i.e. Neck pain, Low back pain) _____

Approximate Year/Month the problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

Have you had this condition in the past? No Yes If yes, when? _____

How is your condition changing? Improving Worsening Not changing

Is your condition? Mild Mild to Moderate Moderate Moderate to Severe Severe

Have you seen any other health care provider for this complaint? No Yes If yes, please explain:

Please Rate Your Pain on a scale of 0 - 10 (0 = no pain and 10 = excruciating pain) _____

How Often do you experience your symptoms?

- Constantly (76-100% of the day) Frequently (51-75% of the day)
 Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Do your symptoms affect your ability to perform daily activities such as working, driving, sleeping, etc.? No Yes

If yes, please explain: _____

What makes your pain Better (for example: adjustments, ice, heat, massage, etc.)? _____

What makes your pain Worse (for example: lifting, bending, standing, etc.)? _____

Describe the Quality of your symptoms: Sharp Dull Numb Burning Shooting Tingling

Tightness Stabbing Throbbing Aching Other: _____

Does your pain Radiate into other areas (such as into arms, legs, etc.)? Yes No

If yes, please explain: _____

Is your pain worse: In the morning During the day At night Stays the same

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Does your pain Radiate into other areas (such as into arms, legs, etc.)? Yes No
If yes, please explain: _____

Is your pain worse: In the morning During the day At night Stays the same

Acknowledgment of Financial Responsibility

Your insurance policy is a contract between you and your carrier. These days, many policies reimburse for at least *some* chiropractic care. But coverage varies from policy to policy and constantly changes.

Our goal is to help you get well but more important, to help you *stay* well. This can be at odds with the profit motives of insurance companies.

So, to protect our freedom to recommend what's truly best for you, we don't attempt to serve two masters. It's your health and you're the boss. So, we do not take insurance assignment. Instead, payment for our services will be your responsibility. This benefits you in several ways:

May increase your coverage. When we file your claim, your company may suspect that we've "sold" you unnecessary care. Their suspicion can reduce your coverage. You're more likely to get the full benefits of your policy if you file your own claims..

You'll receive better care. Doctors under contract with third parties are often prevented from making optimal recommendations. Fearing they will be cut from the "approved" list, they can be pressured into minimizing your problem.

You'll see faster results. When you pay the bill, you'll be motivated to make lifestyle changes and participate more actively in your care. As you would expect, this produces faster, more consistent results.

You'll get more attention. Human nature being what it is, by paying for your own care, you'll be seen as a more responsible, desirable patient.

We will explain the purpose of every procedure. We will supply you with the documents you'll need for filing a claim with your carrier. Please note that some of our services may not be reimbursable under your policy.

I accept financial responsibility for my care and instruct this office to deliver the care that, in their judgment, can best help me in the restoration of my health.

Patient name

Signature

Date

ACKNOWLEDGEMENT AND UNDERSTANDING

I acknowledge and agree to the following:

The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

Concept Therapy is not a treatment for any condition or symptom. Concept Therapy treatment is a care system that is aimed toward the reduction and correction of spinal and nerve blockages so that your body as a whole may function better.

Although Concept Therapy care is one of the safest forms of health care, it is associated with some minor risks and it is my responsibility to be informed about those risks by asking the doctor prior to treatment.

Concept Therapy is a system of health care delivery and therefore, as with any health care delivery system, we cannot guarantee a cure for any symptom, condition or disease as a result of treatment in this office.

Our goal is to provide our patients with the best possible care however, each individual responds to Concept Therapy treatment differently. If we find that, in your case, another health care professional is better able to address your issues we will gladly provide you with the appropriate referral.

I hereby authorize the doctor and staff affiliated with OPRI Health to treat my condition as deemed appropriate.

Signature of Patient: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____