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 the 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 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

RESPIRATORY

❑	❑	Chronic Cough
❑	❑	Asthma
❑	❑	Difficulty Breathing
❑	❑	Spitting Blood
❑	❑	Spitting Phlegm
❑	❑	Wheezing
❑	❑	Pneumonia
❑	❑	Pleurisy
❑	❑	COPD
❑	❑	Tuberculosis
❑	❑	_____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:** _____

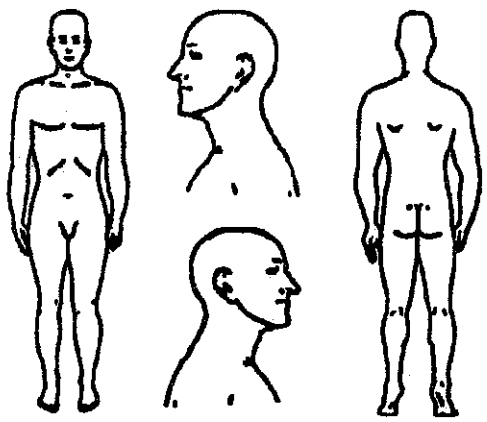
_____

_____

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

COMPLAINT

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

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If yes, please explain: _____

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

FINANCIAL RESPONSIBILITIES

Payment is due at the time of service unless other arrangements have been made. We offer payment arrangements for both cash and insurance patients. OPRI Health does not participate in any insurance plan, however; most policies offer out of network benefits which often pay as well as if we were in network. We are happy to provide a Superbill invoice for the member so you may pursue reimbursement from your insurance company, if applicable.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized be paid directly to me the insured. However, I clearly understand and agree that all services rendered to me are ultimately my personal responsibility. I also understand that if I suspend or terminate my care and treatment any fees for professional services rendered me will be immediately due and payable.

If I have insurance, I am responsible for my insurance deductible, co-payments and any services rejected by my insurance company. I am aware that any outstanding balance more than 120 days old may be sent to a collection agency and there will be an additional fifty dollar fee added.

In the event that the insurance company disputes or rejects the claim I am aware that any outstanding balance is my full responsibility.

I authorize this clinic to release any information pertinent to my case to any insurance company, adjuster and/or attorney involved in this case, and hereby release this clinic of any consequences thereof.

I certify that the information provided in this new patient packet is correct to the best of my knowledge. I will not hold my doctor or any staff member of OPRI Health responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient: _____ Date: _____

Signature of Parent/Guardian: _____ 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: _____