Distance Patient Program

FYI – Becoming a long-distance patient does not detract from the quality of care. If all of the bases are covered in the beginning (labs, consultation, history, forms...) than the quality of treatment and potential outcome are virtually identical to a patient being seen in my office.

Step One: Print and fill-out ALL of the forms below, **completely**. When done, scan, e-mail or fax them back, with any relevant diagnostic tests, to 714-639-8811.

1. Health Consultant Status Form
2. Symptom Survey Form
3. Three Day Food Diary (please list any supplements or medications being taken)
4. BioHealth Diagnostics Survey (Please FAX BACK, even though it says not to)
5. NET Wellness Check Questionnaire (at the end it will give you an opportunity to print or e-mail. E-mail it back to me @ info@advancedhealing.com)

After I receive the above data, I may/may not request additional tests that may be needed to help me, help you. We will discuss this option and I will inform you of all test prices. All testing is done at my cost!

When I receive all of the data needed, I will schedule our initial consult, which is designed to get an in-depth history and ask questions based on the data you have sent me. The initial consult is a 60 minute appointment block ($225 – 30min records review and prep for consult; 30min actual phone time).

Step Two – After I have digested all of the information contained in your intake forms, lab tests and initial consult, I will come-up with a personalized treatment plan. We will set-up another appointment to go over my report-of-findings, discuss the treatment plan and answer any questions – this is a 20 minute appointment ($150). Note: nutritional supplementation and applicable shipping is an additional charge. Follow-up consultations are usually scheduled at two week or one month intervals. Follow-up consultations are done in 10 minute blocks @ $75, with an average being 20-30min's.

Name: _____ Date of Birth: _____

Address: _____City: _____ State: _____

Zip Code:_____ Phone (H or W): _____

Phone (Cell):_____E-Mail: _____

Occupation: _____ Hobbies: _____

Please sign and date below to signify that you have read this page completely and agree with its terms. No warranties or guarantees are given or implied.

Signature: _____ Date:_____

Informed Consent for Telehealth Consultations

To better serve the needs of people in my community, I know offer health care services, within my scope of practice, interactive telecommunications and/or by the electronic transmission of information. This may assist in the evaluation, diagnosis, management and treatment of a number of health care problems. This process is referred to as "telemedicine" or "telehealth." This means that you may be evaluated by me from a distant location. Since this may be different than the type of consultation with which you are familiar, it is important that you understand and agree to the following statements.

1. I, the consulting health care provider will be at a different location from you.

2. I will keep a record of the consultation in my medical record.

3. RELEASE OF INFORMATION: ( ) is authorized to release information from my medical record to any other health care facility or provider to which my care may be transferred.

4. I voluntarily consent to health care services provided by Dr. Ettinger, which may include diagnostic tests, supplements, dietary recommendations and exercise recommendations necessary to assist me with my health challenge.

5. I understand that I may be released before all my health challenges are known or resolved and it is my responsibility to make arrangements for follow-up care.

6. I will not share or release any of your personal information without your prior written consent.

FINANCIAL RESPONSIBILITY

In consideration for the telehealth services rendered to me, I agree to pay for Dr. Ettinger's time incurred by me during my consultations with him, and any products I may purchase.

Print Name _____

Signature_____

Date_____

I have received the ( ) Notice of Privacy Practices