Dr. Ettinger's Distance Patient Program

Step One: Print and fill-out ALL of the forms below, **completely**. When done, scan and email them to info@advancedhealing.com or mail them to 630 S. Glassell St. #103, Orange, CA 92866.

1. Natural Health Consultant Informed Consent
2. Metabolic Assessment Form
3. Three Day Food Diary (please list any supplements or medications you are taking).
4. BioHealth Diagnostics Survey
5. Include any applicable laboratory tests (blood, urine, stool and/or saliva).

After I receive the above data, I may/may not request additional tests that will be needed to help me, help you. If additional testing is required, I will contact you to discuss this. All testing is done at my cost – no mark-up! (USA only - I cannot order tests outside of the USA). When I receive all of the data needed, I will contact you to schedule our initial consult, which is designed to get an in-depth history and ask questions based on the data you have sent me.

Your initial consultation is a 90 minute appointment block - $450 USA.*

- **20 minute for review of all records/forms/tests and prep/research for our consultation.**
- **45 minutes actual phone time.**
- **25 minutes to research/write your personalized treatment protocol (diet, supplements...).** This will be sent via e-mail. Coming-up with your individualized plan may take me a few days, especially if your case is very complex. Please be patient. I want to help you and I will not take any short-cuts with your health.

Any additional time spent on the phone or through e-mail will be $75 per 10 minute block of time. Please be mindful of this. E-mail questions that require only a 'yes' or 'no' answers are free and unlimited. If in-depth responses are needed, via e-mail or phone, fees based on time spent will apply.

Step Two – Follow-up consultations: Follow-up consultations are scheduled at two week or one month intervals or as needed. Fee's are based on time. Please see above paragraph.

Nutritional supplementation and applicable shipping costs are an additional charge. I do not ship outside of the USA. **THERE ARE "NO" RETURNS OR REFUNDS ON PRODUCTS ONCE SHIPPED.**

Name: _____ Date of Birth: _____

Address: _____City: _____ State: _____

Zip Code:_____ Phone: _____

E-Mail: _____ Occupation: _____

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.

Signature: _____

Date: _____

Print Name: _____

Payment Methods and Payment/Scheduling Information

I accept cash, check, all credit cards (form below) and PayPal. PayPal is my preferred payment method.

PayPal is an easy and safe method to make payments. Here is how easy it is:

1. Go to - https://www.paypal.com/home and hit the "sign-up for free button".
2. The prompt will ask you for your e-mail and ask you to create a password.
3. You will fill in your personal information and then your banking information.

If you want to use a credit card please call our office with that information - 714-639-4360.

Making a payment through PayPal:

1. Log into your PayPal account.
2. Click the "pay or send money" button (top of page).
3. Click "**Send Money to Friends and Family" (on the right)** – Not, "Pay For Goods or Services" (which is on the left).

My PayPal information is: info@advancedhealing.com – Marcus Ettinger

Important Information

- In order to hold your appointment for our "initial" consultation I require a full, refundable, deposit of $450.

- If you reschedule or cancel at least 24 hours before your appointment time, your deposit will be refunded or used for your rescheduled consultation.

- If you do not call me at the appropriate time or miss your appointment, your deposit will be forfeited. If you call after your scheduled appointment time, your time on the phone with me will only be for our allotted time bracket – 45 minutes minus the time delay calling-in.

- **No products will be shipped until payment is made.**

I will always answer any questions or concerns you may have with any of the above policies. It's always best to know everything that you and I are getting into before we establish this new relationship.

Signature: _____

Date: _____

Print Name: _____

Authorization for Credit Card Use

PRINT AND COMPLETE THIS AUTHORIZATION AND RETURN.
All information will remain confidential

Name on Card: _____

Billing Address: _____

_____

Credit Card Type: _____Visa _____Mastercard _____Discover _____AmEx

Credit Card Number: _____

Expiration Date: _____

Card Identification Number: _____ (3 digits located on the back of the card. Amex, 4 digits on the front)

Amount to Charge: $ _____ (USD)

I authorize Dr. Marcus Ettinger, DC or his representatives to charge the amount listed above, or agreed upon amount, to the credit card provided herein. I agree to pay for this purchase/service in accordance with the issuing bank cardholder agreement.

Cardholder – Please Sign and Date

Signature: _____

Date: _____

Print Name: _____