Dr. Ettinger's Distance Patient Program

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. Metabolic Assessment 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 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!

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. The initial consult is a 60 minute appointment block @ $225 (30 minute for records review and prep for consult; 30 minutes actual phone time). Any additional time spent on the phone or through e-mail will be $75 per 15 minute block of time. I usually only need 30 minutes of phone time, but you may also have 15, 30… minutes of questions or concerns that need to be taken-up. Please be mindful of this. Yes or no types of e-mails are free and unlimited. If in-depth responses are needed, via e-mail or phone – see the above paragraph for costs.

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/or answer any questions. This is a 15-30 minute appointment ($75-150). Note: nutritional supplementation and applicable shipping costs are an additional charge. I do not ship outside of the USA.

Step Three – Follow-up consultations are scheduled at two week or one month intervals. (Step Two) fee schedule applies for all follow-up appointments as well.

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.

Print Name ____

Signature____

Date____

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

Making a payment through paypal: 1) Log into your PayPal account. 2) Hit the "pay or send money" button. 3) Hit the "Send money to friends and family".
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, non-refundable*+, deposit of $225.

- *If you reschedule or cancel altogether, within 24 hours of your appointment time, your deposit will not be forfeited. 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 – 30 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.

Respectfully,

Dr. Ettinger

Print Name ____

Signature____

Date____

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 to charge the amount listed above, or agreed upon amount, to the credit card provided herein. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder – Please Sign and Date

Signature: ____

Date: ____

Print Name: ____