# HEALING THE EYE & WELLNESS CENTER

**Dr. Edward Kondrot, MD (H), CCH, DHT**
**7100 East Cave Creek Road Suite # 111**
**Cave Creek, AZ 85331 480 595 3181**

## PATIENT REGISTRATION FORM
## PLEASE PRINT

**DATE** **SOCIAL SECURITY #**

**LAST NAME** **FIRST NAME** **M.I.**

**STREET ADDRESS**

**CITY** **STATE** **ZIP**

**DAYTIME PHONE** **EVENING PHONE** **CELL PHONE**

**DATE Of BIRTH** **MALE** **FEMALE** **AGE**

**E-MAIL ADDRESS**

**WOULD YOU LIKE TO RECEIVE OUR E-MAIL NEWSLETTER?**
**YES** **NO** **INITIALS**

**HOW DID YOU HEAR ABOUT HEALING THE EYE AND & WELLNESS CENTER (Dr. Edward Kondrot):**

**If a referral, whom may we thank?_____**

**IN CASE OF EMERGENCY CONTACT INFORMATION:**

**NAME OF CONTACT:_____**
**PHONE#_____**

**NAME OF CONTACT:_____**
**PHONE #_____**
**MAY WE LEAVE A MESSAGE ON YOUR HOME PHONE NUMBER REGARDING YOUR CARE AT HEALING THE EYE AND WELLNESS CENTER?**

**_____**
**YES NO INITIALS**

**PLEASE LIST ANY OTHERS: SPOUSE OR FAMILY MEMBER TO WHOM WE MAY RELEASE YOUR PRIVATE INFORMATION.**

**NAME: PHONE: RELATIONSHIP:**

**_____**
**_____**
**_____**

**PRIMARY REASON/COMPLAINT FOR SEEING THE DOCTOR:**
**_____**
**_____**
**_____**

**_____**
**SIGNATURE ( PATIENT/GUARDIAN ) DATE**

# FINANCIAL AGREEMENT

**NAME: _____**

**I understand that payment in full is expected at the time of services are rendered unless prior financial arrangements have been made. I understand that Healing the Eye and Wellness Center, the office of Dr. Edward Kondrot will NOT PROCESS OR ASSIST IN ANY INSURANCE OR MEDICAL BILLING OR CLAIMS.**
**I understand it is my sole financial responsibility to Healing the Eye and Wellness Center and Dr. Edward Kondrot, for ALL charges incurred.**

**I also understand that Healing the Eye and Wellness Center has the right to assess a cancellation charge to my billing information of up to ½ of my consultation fee for all appointments not cancelled within 1 week (business) of my appointment.**

**NAME:(PRINTED)_____**

**_____**
**PATIENT SIGNATURE DATE**

**Signature of responsible party if not the same as**

**above:_____**

I understand that in seeking medical treatment from Edward C. Kondrot, MD(h), CCH, DHt, FCOS, who will hereinafter be referred to as the "Doctor", whether speaking of one or more of them, I am not required to use him/her as my doctor for myself or my family as there are other doctors as well qualified who practice medicine in the specialty of ophthalmology, optometry, naturopathy, acupuncture and homeopathy that he/she is willing to refer me to them.

I understand that if I waive any liability for his/her care of me and my family, I will help the Doctor keep down the expenses of his/her practice of medicine due to savings in avoiding malpractice insurance and malpractice lawsuits, the expenses of which would otherwise be passed on to me and his/her other patients in higher fees. I enter into this contract voluntarily and I understand I am waiving my right to bring a claim against the Doctor for any negligent act or omission he may commit in his treatment of me or for any breech of the contractual obligation to me to render to me that standard of medical care which is rendered in this contract applies to all of his/her medical care to me.

I specifically release the Doctor from any liability to me and I hereby release, discharge and acquit the Doctor from any and all claims for loss, damage or injury of any nature whatsoever to my person, my family or estate, resulting in any way, form or in any fashion arising from, connected with or resulting from the Doctor's medical treatment of me or my family whether caused by malpractice or negligent acts of the Doctor, his/her agents, or employees or servants or otherwise. This contract is clearly intended to protect the Doctor against his own negligence and I so understand it.

I voluntarily enter into this contract in order to induce the Doctor to render to me medical as well as alternative therapies at his or her most reasonable cost.

Additionally, if the aforementioned release and/or waiver is determined by any court to be void and not binding upon me, I am willing to submit any claim for loss, damage or injury of any nature whatsoever to my person or estate resulting in any way form or in any fashion arising from connected with or resulting from the Doctor's treatment of me whether caused by malpractice, breach of contract or negligent acts of the Doctor, his agents, employees, servants or otherwise, to binding arbitration. In such arbitration I agree that there shall be three arbitrators, two of them shall be medical doctors with qualifications similar to Dr. Kondrot in Homeopathy, Ophthalmology or Optometry. Each party shall choose one arbitrator and the two arbitrators shall choose the third. The decision of the arbitrators shall be final and binding upon me with respect to the decision of liability and amount.

In witness whereof; I have signed this contract, this
_____ day of _____ 20_____

WITNESS:_____

Patient Signature_____

Patient Name: (Print)_____

# TREATMENT CONSENT

**DR. Edward C. Kondrot MD, (H),CCH,DHt,FCOS**

**I AUTHORIZE THE PERFORMANCE UPON _____**
**(MYSELF, NAME OF PATIENT) AN ALTERNATIVE MEDICINE EVALUATION WHICH INCLUDES BUT ARE NOT LIMITED TO, HOMEOPATHIC, MICROCURRENT, NURTRITIONAL, COLOR, VISION AND IV THERAPIES. I MAY OR MAY NOT BE A CANDIDATE FOR THE THERAPIES LISTED AND I AM SEEKING ADVICE FROM DR. EDWARD C. KONDROT.**

**THESE HAVE NOT BEEN PROVEN THROUGH SCIENTFIC RESEARCH. WHILE TRYING THE SUGGESTED APPROACH, I WILL REMAIN UNDER THE CARE OF MY MEDICAL DOCTOR AND WILL HAVE MY HEALTH/VISION CHECKED PERIODICALLY. HE OR SHE MAY RECOMMEND OTHER TREATMENT, SOME MAY NOT BE AVAILABLE AT THE TIME OF CONSENT. IF THIS IS THE CASE I WILL EVALUATE MY OPTIONS.**
**THE FOLLOWING TREATMENTS ARE OPTIONAL AND HAS SPEFICICALLY BEEN DISCUSSED AS INDICATED BY MY INITIALS:**

**IV TREATMENT; INITIAL _____**
**INCLUDING BUT NOT LIMITED TO; MYERS NUTRITIONAL COCKTAIL, OZONE, CHELATION, PK PROTOCOL:**

**I UNDERSTAND THE NATURE AND RISK OF ALTERNATIVE THERAPIES AND THE POSSIBLE COMPLICATIONS. I WILL BE USING ALTERNATIVE THERAPIES AS A COMPLIMENT TO MY REGULAR MEDICAL PROGRAM AND I WILL NOT DISCONTINUE ANY MEDICATION OR TREATMENT WITHOUT THE PRIOR APPROVAL OF MY EXISTING DOCTOR. I ALSO UNDERSTAND THAT THERE IS NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN BY ANYONE AS TO THE RESULT THAT MAY BE OBTAINED. I HAVE BEEN EXPLAINED AND I UNDERSTAND THE ABOVE AND I REQUEST TO HAVE THE PROCEDURE(S) DONE.**

**PATIENT/GUARDIAN DATE**

**WITNESS DATE**

**Nutritional Research & Publishing**
**7100 E. Cave Creek Road**
**Suite 111**
**Cave Creek, AZ 85331**

**Credit Card Authorization**

Credit Card Type Visa MasterCard Discover

Card Number _____

Expiration Date _____ CCV#_____

Name of Cardholder _____

Billing Address _____

Amount to Bill _____

I hereby give permission to the staff of Nutritional Research & Publishing/Healing the Eye and Wellness Center to use the account listed above.

_____ _____
Cardholder Signature Date

**Healing the Eye and Wellness Center**
**7100 E. Cave Creek Road,**
**Suite #111**
**Cave Creek, AZ 85331**
**P: 480 595 3181**
**F: 480 595 0094**

# Pacemaker and or Defibrillator Release

## Treatment with Microcurrent Stimulation

**(If none, please write "none" and sign)**

**Patients Name: _____** **Date: _____**

**Is cleared for daily treatment of microcurrent stimulation. Treatment duration is between 30 to 60 minutes with 20 to 100 micro amps. (0.30 to 970 HZ).**
**Location of treatment will be head, eyes and abdomen. No treatments will be on the area of the chest.**

**From a cardiac perspective, I feel my patient is in good health to receive treatment.**

**Physicians Name: _____**

**Address: _____,** **State: _____ Zip Code: _____**

**Physicians Signature: _____**