

HEALING THE EYE & WELLNESS CENTER

Dr. Edward Kondrot, MD (H), CCH, DHT
Dr. Oddveig Myhre NMD, MS
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
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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
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HEALING THE EYE AND WELLNESS CENTER

Dr. Edward C. Kondrot, MD,(H),CCH, DHT

Dr. Oddveig Myhre, NMD, MS

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 and Dr. Oddveig Myhre 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, Dr. Oddveig Myhre 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:_____

HEALING THE EYE AND WELLNESS CENTER

Dr. Edward C. Kondrot MD, (H), CCH, DHT
Dr. Oddveig Myhre, NMD, MS

Doctor/Patient Contract

I understand that in seeking medical treatment from Edward C Kondrot, MD(H), CCH, DHT, FCOS, Oddveig Myhre, NMD., 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 breach 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 from 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 from 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 and Dr. Oddveig Myhre in Naturopathy. 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 NAME: (PRINT)

DATE:

PATIENT SIGNATURE