Patient Information

Name: _____ Date: _____

Birthdate (month/date/year): _____ /_____ /_____ Age: _____ Gender: _____

Phone: _____ Email: _____

Address: _____ City: _____ Zip code: _____

Emergency Contact: _____ Phone: _____

Relationship: _____ How did you hear about our office? _____

Reason for visit: _____ When symptoms appeared: _____

Informed Consent to Pulsed Electromagnetic Field Therapy

I hereby certify that I am at least 18 years of age, or have provided a written parental/guardian consent to be treated. I confirm that I am not pregnant and that I do not have a pacemaker or any other electronic-based implants. I understand that this demonstration is not diagnostic and that a medical practitioner may not always be conducting this and future sessions. Further, I release Dr. Kenneth M. Toy and his staff from any and all liability from complications which may arise from treatment. I have read and understand this consent and desire to receive therapy pursuant to the terms and conditions.

Signature: _____ Date: _____

Price Acknowledgment and Past Due / Collection Agreement

After the initial complimentary session, I understand that there is a $50.00 charge per treatment to receive Pulsed Electromagnetic Field Therapy. I acknowledge that all payments are due at the time of service, unless prior payment arrangements have been made with Dr. Kenneth M. Toy and his staff. In the event that my account has an outstanding balance that exceeds 30 days with no contact from me, my account will be forwarded to the following collections agency:

American Capital Ent., Inc.

41870 Kalmia Street Suite 120

Murrieta, CA 92562

I have fully read and understand this agreement and any questions I may have concerning this matter have been answered by Dr. Kenneth M. Toy and his staff.

Signature: _____ Date: _____