

# Helen Foundation Clinic

## ENROLLMENT FORM

*(Please print & complete all blanks using printing)*

Name \_\_\_\_\_ Date \_\_\_\_\_ EC \_\_\_\_\_

Birth \_\_\_\_\_ Age \_\_\_\_\_ Weight \_\_\_\_\_ Female \_\_\_\_\_ Male \_\_\_\_\_ Diary Total Score \_\_\_\_\_

Diagnosis: Arthritis \_\_\_\_\_ Asthma \_\_\_\_\_ Carpal Tunnel \_\_\_\_\_ Chronic Fatigue \_\_\_\_\_  
Crohn's \_\_\_\_\_ Fibromyalgia \_\_\_\_\_ Lupus \_\_\_\_\_ Multiple Sclerosis \_\_\_\_\_ Parkinson's \_\_\_\_\_  
Osteoarthritis \_\_\_\_\_ Rheumatoid Arthritis \_\_\_\_\_ Polymyalgia Rheumatica \_\_\_\_\_ Other \_\_\_\_\_

Diagnosis by: Family physician \_\_\_\_\_ Rheumatologist \_\_\_\_\_ Other \_\_\_\_\_

Personal physician \_\_\_\_\_ Phone \_\_\_\_\_ - \_\_\_\_\_ Fax \_\_\_\_\_ - \_\_\_\_\_

Medical insurance company \_\_\_\_\_ Policy no. \_\_\_\_\_

\* \* \* \*

Winter address \_\_\_\_\_ email \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

Phone \_\_\_\_\_ - \_\_\_\_\_ (home) \_\_\_\_\_ - \_\_\_\_\_ (work) \_\_\_\_\_ - \_\_\_\_\_ (cell)

Dates in residence \_\_\_\_\_ Best time to phone \_\_\_\_\_

\* \* \* \*

Summer address \_\_\_\_\_ e-mail \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

Phone \_\_\_\_\_ - \_\_\_\_\_ (home) \_\_\_\_\_ - \_\_\_\_\_ (work) \_\_\_\_\_ - \_\_\_\_\_ (cell)

Dates in residence \_\_\_\_\_ Best time to phone \_\_\_\_\_

***(Following section to be completed by Enrollment Consultant)***

Supervising physician \_\_\_\_\_ Ph \_\_\_\_\_ - \_\_\_\_\_ Fax \_\_\_\_\_ - \_\_\_\_\_

Qualifying Medical Exam Date \_\_\_\_\_ Time \_\_\_\_\_

Shower End Medical Exam Date \_\_\_\_\_ Time \_\_\_\_\_

Three-Month Medical Exam Approximate Date \_\_\_\_\_

Instruction Manual given Approximate Date \_\_\_\_\_

Reviewed with client Date \_\_\_\_\_

Microdose Diaries selected to be used by client:

<input type="checkbox"/> Joint & Soft Tissue	<input type="checkbox"/> Prostate	<input type="checkbox"/> Sarcoidosis
<input type="checkbox"/> Lung	<input type="checkbox"/> Vertigo	<input type="checkbox"/> Parkinson
<input type="checkbox"/> Bowel	<input type="checkbox"/> Eyes	<input type="checkbox"/> Nerve
<input type="checkbox"/> Carpal Tunnel Syndrome	<input type="checkbox"/> Eczema	<input type="checkbox"/> Neuropathy
<input type="checkbox"/> Heart	<input type="checkbox"/> Brain	

Completed enrollment forms and first-day diary copies to office Date \_\_\_\_\_

Special arrangements if any \_\_\_\_\_

# Helen Foundation Clinic

## DEFINITION OF SERVICES PROVIDED

The Microdose Therapy education program lasts three months, the follow-up program another nine months, and consists of the following parts:

### The three-week Microdose Shower for relief (minimum symptom state)

1. Review the Microdose Shower section of the Instruction Manual
2. Daily complete the Diary(ies) selected before and while taking Microdose medicines
3. Complete medical history to give to the supervising physician at first appointment
4. Read the Instruction Manual before the Qualifying Medical Exam
5. Have the Qualifying Medical Examination
6. Give a blood sample for food allergy test
7. Begin using cortisol according to Instruction Manual with dosages defined
8. After receiving the results of the food allergy lab test, eat only '0' – rated foods
9. Avoid over work and exercise
10. Telephone in diary scores to the Helen Foundation Staff beginning of third week and learn if a Repeat Microdose Shower is needed. (If you will have achieved only partial relief during the Shower, you will be asked to repeat the Microdose Shower with an antibiotic.)
11. Have Shower End Medical Exam after the last day of the Shower(s)

### First Month after Shower

1. Read Instruction Manual First Month instructions
2. Record the prescribed Microdose Booster dosages in your Instruction Manual
3. Add rated, pure foods back to your diet of '0' – rated foods one at a time
4. Use the assigned five-day Microdose Booster regimen Monday through Friday
5. Continue to complete the Diary(ies) daily at the same time of day

### Second Month after Shower

1. Read Instruction Manual Second Month instructions
2. Decide: use cortisol self-administration or the Monday through Friday use for rest of life
  - a. Learn what a flare is
  - b. Learn how to quench flares with the Microdose Booster
  - c. Learn how to use the Microdose Mini-Booster
  - d. Learn how to modify the Microdose Booster
3. Continue to complete the Diary(ies) daily at the same time of day
4. Learn the rest of life instructions
5. Telephone diary scores to the Helen Foundation during the third week of the month
6. Fax or mail copies of all completed diaries into the Helen Foundation during third week of the month
7. Have the Three-Month medical examination

### Months 4 -12 of the Microdose Therapy program

1. Report diary scores monthly to the Helen Foundation staff
2. Discuss unusual experiences as they occur

I have read this document and understand the Microdose Therapy program. I am aware of the risks and agree to enter the program.

Signature \_\_\_\_\_

Printed name \_\_\_\_\_

Date \_\_\_\_\_

# Helen Foundation Clinic

## MEDICAL HISTORY

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Diabetes? Yes No Is it controlled? Yes No

What is your average blood sugar level? \_\_\_\_\_ Are you currently on insulin? Yes No

On other anti-diabetic drugs? Yes No High blood pressure? Yes No Is it controlled? Yes No

What is the average range of your blood pressure? \_\_\_\_\_

Are you currently taking medications for high blood pressure? Yes No

History of congestive heart failure? Yes No

History of ulcers and/or gastrointestinal bleedings? Yes No

If yes, when? \_\_\_\_\_ Is it under control? Yes No

Osteopenia? Yes No Osteoporosis? Yes No

Last bone density test (date) \_\_\_\_\_ Results \_\_\_\_\_ T-score \_\_\_\_\_

Are you currently taking medications for osteoporosis or osteopenia? Yes No

Glaucoma? Yes No Is it controlled? Yes No

Are you currently on medications for glaucoma? Yes No

History of tuberculosis? Yes No

History of vascular necrosis? Yes No

Do you have any infection now? Yes No If yes, define \_\_\_\_\_

Do you have water retention now? Yes No Is it controlled? Yes No

Are you currently taking prednisone, prednisolone, medrol, dexamethasone, or triamcinolone? Yes No

If yes, which? \_\_\_\_\_ Daily dose \_\_\_\_\_ mg

Have you taken one of the listed above drugs in the past? Yes No

Which? \_\_\_\_\_ How much? \_\_\_\_\_ mg/day

How long did you take it? \_\_\_\_\_ When did you stop taking it? \_\_\_\_\_

Did it help you? Yes No

Did you have any reactions or side effects because of the drug? Yes No

If yes, what reactions? \_\_\_\_\_

Have you been allergic or intolerant to doxycycline or tetracycline? Yes No

If yes, what were the symptoms? \_\_\_\_\_

Do you have any known food sensitivities? Yes No

If yes, list the foods to which you are sensitive \_\_\_\_\_

Do you have surgeries planned? Yes No

What surgeries? \_\_\_\_\_ When? \_\_\_\_\_

# Helen Foundation Clinic

## MEDICAL HISTORY

*List all the medications you are currently taking*

Medication	Dose	Reason for taking

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

### Friends and relatives who might be helped by Microdose Therapy:

Name \_\_\_\_\_ Phone \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Disease \_\_\_\_\_ / \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Disease \_\_\_\_\_ / \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Disease \_\_\_\_\_ / \_\_\_\_\_

# Helen Foundation Clinic

## Health Insurance Portability and Privacy Accountability Act Informed Consent

As of August 14, 2002, the government ruled that healthcare practices must be in compliance with this act, a privacy ruling. This notice describes how health information about you, as a patient of the Helen Foundation Clinics, may be used and disclosed, and how you can get access to your health information. This required by the Privacy Regulations created by Health Insurance Portability and Privacy Accountability Act of 1996. The Helen Foundation Clinics are dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We must provide you with the following important information.

### Use and Disclosure of Your Health Information in Certain Special Circumstances:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

### Your Rights Regarding Your Health Information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate your requests as much as possible.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care options. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing.
4. You may ask to have your health information amended if you believe it is incorrect, incomplete, and as long as the information is kept by or for this practice. To request an amendment, your request must be made in writing. You must provide a reason supporting your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with the Board of Medical Examiners, or the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. The Helen Foundation Clinics practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

*(If you have any questions regarding this notice or health information privacy policies, please contact us.)*

I acknowledge that I have been presented with a copy of the Helen Foundation Clinic's Notice of Privacy Practices and am aware that all clinics' personnel may have access to private information in order to service their patients.

\_\_\_\_\_  
Client name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

*(If client is a minor)*

\_\_\_\_\_  
Print client name

\_\_\_\_\_  
Parent or guardian signature

\_\_\_\_\_  
Print parent or guardian name

# Helen Foundation Clinic

*Microdose Therapy* Name \_\_\_\_\_

## JOINT & SOFT TISSUE

	Date																		
	Jaw																		
	Upper Spine																		
	Lower Spine																		
	Hip	L																	
		R																	
J	Knee	L																	
		R																	
O	Ankle	L																	
		R																	
I	Heel	L																	
		R																	
N	Toes	L																	
		R																	
T	Shoulder	L																	
		R																	
S	Elbow	L																	
		R																	
	Wrist	L																	
		R																	
	Thumb	L																	
		R																	
	Pointer Finger	L																	
		R																	
	Third Finger	L																	
		R																	
	Ring Finger	L																	
		R																	
	Little finger	L																	
		R																	
S	Neck																		
O	Shoulder-to	L																	
F	-neck	R																	
T	Shoulder	L																	
		R																	
U	Upper arm	L																	
		R																	
P	Lower arm	L																	
		R																	
S	Hip	L																	
		R																	
E	Thigh	L																	
		R																	
S	Calf	L																	
		R																	
	Upper back																		
	Lower back																		
	Headache																		
	Stiffness, a.m.																		
	Fatigue																		
	Brain Fog																		
	<b>TOTAL SCORE</b>																		
	<b>Date</b> →																		
	<b>mg cortisol</b>																		

# Helen Foundation Clinic

## Microdose Diary Selector

Name \_\_\_\_\_

**Instructions:** Rate each of the following symptoms on the scale of 0 to 10 with 10 being the worst possible. Then, with your enrollment counselor, select appropriate Microdose Diaries.

**Good News!** These symptoms have been known to ameliorate in other who have enrolled in Microdose Therapy.

ACTIVITIES OF DAILY LIVING	
Balance	
Buttoning	
Chewing	
Choking	
Cogwheel arm movements	
Control, arms	
Control, legs	
Dressing	
Tremors, arms	
Tremors, legs	
<b>TOTAL</b>	

LUNGS	
Asthma-like spasms	
Congestion	
Cough	
Exhaustion	
Inhaler use frequency	
Shortness of breath	
Sneezing	
Sputum (phlegm)	
Tightness of chest	
Wheezing	
<b>TOTAL</b>	

BLADDER	
Bloody urine	
Cloudy urine	
Frequent urination	
Force of urine stream	
Incomplete emptying	
Night time urination	
Painful urination	
Slow urine flow	
Straining	
Urgency	
<b>TOTAL</b>	

CARPAL TUNNEL	
Numbness, hand	L
	R
Numbness, arm	L
	R
Pain, hand	L
	R
Pain, arm	L
	R
Pain, wrist	L
	R
<b>TOTAL</b>	

BRAIN	
Behavior, abnormal	
Concentration	
Confusion	
Decision making	
Depression	
Hopeless feelings	
Math ability	
Moodiness	
Suicide thoughts	
Unusual thinking	
<b>TOTAL</b>	

NERVES	
Burning sensations	
Cold sensations	
Numbness, arms	
Numbness, legs	
Numbness, feet	
Sciatica	
Tingling, arms	
Tingling, legs & feet	
Walking	
Writing	
<b>TOTAL</b>	

LEGS	
Cold feelings	
Hot feelings	
Pain	
Restless legs	
Shooting pains	
Walking, slow	
Walking, halting	
Walking shuffling	

BOWEL	
Abdominal pain	
Bloating	
Blood in stool	
Bowel spasms	
Constipation	
Diarrhea	
Loss of appetite	

BACK PAIN	
Pain, upper spine	
Pain, lower spine	
Pain, upper muscles	
Pain, lower muscles	

# Helen Foundation Clinic

Weakness	
<b>TOTAL</b>	

<b>TOTAL</b>	

<b>TOTAL</b>	

## Microdose Therapy™ Program Agreement

**NO GUARANTEE** I understand there is no guarantee of results using the Microdose Therapy™ program. If I fail to get significant relief during the repeat Microdose Shower, I am encouraged to apply to the Helen Foundation Clinic Finance Committee for a partial refund. Compliance to instruction and % relief are issues considered by the Committee. Significant relief is 25% or greater symptom improvement.

**IF I CHANGE MY MIND** I understand that I have 72 hours to change my mind after enrolling in and have not begun the Microdose Therapy program to get a full refund of the money I have paid for the program. If I change my mind after 72 hours and before starting the Microdose Shower, there will be a charge of \$495 to cover the cost of creating my computer data base, establishing my qualifying medical examination with the assigned physician, and making recommendations to the assigned physician.

**MEDICAL DISQUALIFICATION** I understand that if the assigned physician performing the qualifying medical exam disqualifies me from entering the Microdose Therapy program, the money paid for the program less the cost of the qualifying medical exam and the food allergy test, if done, will be refunded within 30 days.

**VOLUNTARY WITHDRAWAL** I understand that if I voluntarily withdraw from the Microdose Therapy program after starting, I may apply to the Helen Foundation Clinic Finance Committee for a refund. The Committee will only consider the refund when the program was failing to provide significant relief. In the event a refund is granted, the money paid for the program less the costs of services rendered will determine the refund amount. Compliance to instructions and % relief are issues considered by the Committee.

**MEDICAL INSURANCE** I understand the Helen Foundation does not have a staff to file insurance claims due to the various insurance plans and companies. If I wish to be reimbursed by my insurance plan, I must apply directly to my insurance company. I further understand that medical education programs might not be reimbursable. Microdose Therapy is in main part an education program. I must get an insurance claim form from my insurance company, complete form using the 'Cost Schedule of Microdose Therapy' and 'Helpful Insurance Codes' and submit the completed forms to my company.

### Cost Schedule of Microdose Therapy

Qualifying Medical Exam  
 Monitoring Medical Exam each (x 2)  
 Food Allergy Test for 90 foods  
 Microdose Shower Education, 3 to 6 weeks  
 Maintenance Education, two months  
 Follow-up Support, nine months  
 Total Cost

### Helpful insurance codes

99205  
 99214  
 allergy testing (x 90) 86003  
 classroom education 98962  
 telephone education 99373  
 education materials 99071

Having read and understood the disclosures of this Enrollment Form and Finance Agreement and being fully aware of the risks of participating in the Microdose Therapy program, I agree to enter the program. Furthermore, I agree to and hold the Helen Foundation Clinic and the Helen Foundation free of any liability for services rendered.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

# Helen Foundation Clinic

## Helen Foundation Clinic Finance Agreement

### Select Payment Option

**CHECK**                      Check number \_\_\_\_\_ Amount \$ \_\_\_\_\_

**CREDIT CARD**    \_\_\_ Visa    \_\_\_ MasterCard    \_\_\_ Discover    \_\_\_ American Express

Account number \_\_\_\_\_

Expiration Date \_\_\_\_\_ Code \_\_\_\_\_

Client Signature \_\_\_\_\_

**CARECREDIT**                      CareCredit plan selected \_\_\_\_\_

\_\_\_\_\_ Number Payments              Payment Amount \$ \_\_\_\_\_

Client Signature \_\_\_\_\_

**MI FINANCIAL**                      MI Financial plan selected \_\_\_\_\_

\_\_\_\_\_ Number Payments              Payment Amount \$ \_\_\_\_\_

Client Signature \_\_\_\_\_

Printed Name \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Driver's License \_\_\_\_\_ State \_\_\_\_\_

Date \_\_\_\_\_ Time \_\_\_\_\_

**GUARANTOR**                      Guarantor's Signature \_\_\_\_\_

Printed Name \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Driver's License \_\_\_\_\_ State \_\_\_\_\_

Consultant \_\_\_\_\_

# Helen Foundation Clinic

Telephone number \_\_\_\_\_

## MI Financial

I grant MI Financial to use the information on my CareCredit application to make an offer to finance the loan I wish to make. Should MI Financial be successful, I understand:

1. I may prepay all or any part of the principal plus accrued interest thereon at anytime without penalty.
2. I am responsible, and any endorser is responsible, for informing MI Financial of any change or changes in name, address, and telephone number or social security number.
3. Payments are due on the first of each month and regarded late after the 10<sup>th</sup> day of the month of the payment. The late payment penalty is \$10 per month late.
4. Upon payment default, MI Financial may declare the balance of this promissory note, including principal, interest and late charges, immediately due and payable. MI Financial may disclose the fact that I have defaulted and other relevant information to credit bureau organizations. I, the borrower, agree that if MI Financial considers it necessary to refer all or part of the unpaid principal or interest evidenced by this note to any attorney or collection agency for collection, the borrower agrees to pay all charges and other costs, including attorney fees, that are allowed by federal and state laws and regulations that are necessary for the collection of these amounts.
5. This promissory note is governed, construed and interpreted by, through and under the Laws of the State of Arizona.
6. MI Financial is owned separately and independent of Microdose International, Inc., the Helen Foundation Clinics and the Helen Foundation.

Borrower signature \_\_\_\_\_ Date \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip code \_\_\_\_\_  
Social Security number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Guarantor signature \_\_\_\_\_ Date \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip code \_\_\_\_\_  
Social Security number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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# Helen Foundation Clinic

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Microdose Shower Education, 3 to 6 weeks
Maintenance Education, two months
Follow-up Support, nine months
Total Cost

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	99205
	99214
allergy testing (x 90)	86003
classroom education	98962
telephone education	99373
education materials	99071

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# Helen Foundation Clinic

Calf	L																	
	R																	
Upper back																		
Lower back																		
Headache																		
Stiffness, a.m																		
Fatigue																		
Brain Fog																		
<b>TOTAL SCORE</b>																		
<b>mg cortisol</b>																		