AGREEMENT BETWEEN PHYSICIAN AND PATIENT

RA-MAR CLINIC

For, and in consideration of, medical care rendered to me by Dr. Ray Evers (herein refer to as Physician), in order to safeguard my choice of treatment while in the clinic, and in order to enjoy the benefit of my physician's medical advice without unreasonable pressure from goverment and other parties, and in the interest of preserving the confidentiality of private affairs contained in my medical records, I, [redacted] (herein referred to as Patient), hereby freely enter in this Agreement Between the Physician and Patient:

1. Clinic Treatment: I hereby agree to undergo clinical treatment at RA-MAR CLINIC under my Physician's care. I make this decision of my own free will. I understand that I am free to accept or reject clinic care, or to choose treatment without a clinical stay. I hereby authorize and request my Physician, [redacted] to continue my treatment in the clinic.

2. Direct Billing: I understand that, as a private patient, I shall be responsible for the payment to RA-MAR CLINIC which includes my Physician's professional fee. This method of payment is called "DIRECT BILLING" under Third Party Payor, should I be entitled to reimbursement for medical expenses by my insurance policies, by Medicare insurance or other parties, I will request that they reimburse me for these expenses, and not my Physician.

3. Clinical Government-Required Committees: I understand that you, as my Physician, cannot assure me that the medical services recommended will be approved for reimbursement under Federal regulations or by other insurance programs. Should the government's insurance carriers or intermediaries or third parties find reason to deny me insurance benefits because of supposed "lack or medical necessity", I shall not hold my physician responsible for any of my expenses of clinic treatment.

I specifically request that you, as my attending Physician, prescribe for my diagnosis and treatment based upon your individualized judgment and discretion, and not upon numerical averages in rulebooks or so-called "norms", "schemes" or "standards", or by whatever name, as established by any individual, group, agency, insurance company or "service corporation", government agency, program, union, fraternal body, or any other organization or person.

4. I understand the type of therapy given at RA-MAR CLINIC may not be in perfect agreement with the so called orthodox methods of treatment as approved by the AMA, FDA, or AMA. I understand that the type or therapy given here is the type that the Physician and I both agree is the correct future of medicine. (By the use of nutrition, enzymes, physical therapy, magnetic medicine, use of pyramids, etc. or any other modalities that may be used to benefit mankind). We understand that some of the diseases treated are purely by the non-toxic nutritional and metabolic methods that very few drugs or surgery is recommended. I came seeking this type of treatment for my physical ailments and have a complete diagnosis made by my Physician and I agree to have this therapy even though it may not be orthodox. I elect this of my own free-will and discretion and I feel that I am entitled as a Citizen to have the freedom of choice as to how I desire my body treated, by whom, where, and it be done without interference from Governmental bureaucratic medical agencies. I do willingly request this type of therapy and will abide by the results obtained.

5. Confidentiality: I also understand that, as a private Patient, the informatic recorded in my medical record is to remain private and confidential. Such in formation is not to be released without my written consent given after the da of this Agreement, and for the sole purpose which I Designate.

I HAVE READ THIS AGREEMENT CAREFULLY, AND HAVE FREELY ASKED ANY QUESTIONS IN ORDER TO FULLY UNDERSTAND IT. I HEREBY ENTER INTO THIS AGREEMENT OF MY OWN FREE-WILL, BEFORE THE WITNESSES WHICH HAVE SIGNED IN MY PRESENCE AND AS OF THIS DATE.

WITNESS: Daphne Pope

RESIDENCE: _____

[redacted]

PATIENT, RESPONSIBLE GUARDIAN OR A

SIGNED AT _____
CITY & STATE

ON: _____ 19____ AT _____
DATE TIME

AUTHORIZATION FOR MEDICAL ~~AND/OR SURGICAL~~ TREATMENT

I, the undersigned, a patient in this hospital, hereby authorize Dr. Ray Evers and whomever he may designate as his assistants to administer such treatment as is necessary, and to perform the following operation None
NAME OF OPERATION
and such additional operations or procedures as are considered therapeutically necessary on the basis of findings during the course of said operation. I also consent to the administration of such anesthetics as are necessary, with the exception of None
NONE, SPINAL ANESTHESIA, OR OTHER
Any tissues or parts surgically removed may be disposed of by the hospital in accordance with accustomed practice.

I hereby certify that I have read and fully understand the above Authorization for Medical and/or Surgical Treatment, the reasons why the above mentioned surgery is considered necessary, its advantages and possible complications, if any, as well as possible alternative modes of treatment, which were explained to me by Dr. Ray Evers. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Date _____ Signed [redacted]
PATIENT

Witness _____ Or. _____
NEAREST RELATIVE

Relationship to Patient _____

Both authorizations must be signed by the patient, or by the nearest relative in the case of a minor or when patient is physically or mentally incompetent.

AUTHORIZATION FOR RELEASE OF INFORMATION

Authorization is hereby granted to release to the _____
NAME OF INSURANCE COMPANY OR COMPANIES
such information as may be necessary for the completion of my hospitalization claims.

Date _____ Signed [redacted]
PATIENT

Or. _____
NEAREST RELATIVE

Relationship to Patient _____