



Quantum Healing Institute

212 Old Grande Blvd., Ste. C-114

Tyler, TX 75703

Ph: 903-939-2069 Fax: 903-939-2088

Dear New Patient:

Congratulations! You are about to take the Quantum Leap!

We welcome you to the Quantum Healing Institute. If you are ready, your life could change dramatically. Remember- If you THINK it and you BELIEVE in it, you can and will MANIFEST it.

Here at the Quantum Healing Institute we are going to THINK, BELIEVE and MANIFEST right along with you so prepare your heart for the miracles that can happen and so you can get the most out of your visit with us. Here's how you can start!

- 1.) You will need to fill out the enclosed medical history packet completely and sign all papers that need your signature.**
- 2.) Fill out the 3-day food diary.**
- 3.) Write a summary (no more than 3 pages) of your health history and challenges from birth to present time using the best timelines you can. You can use your age or the specific years to outline this.**
- 4.) Make a list of your primary and secondary concerns to address while you are in your session with the Doctor or Nurse Practitioner. Also include a list of questions that you need answered.**
- 5.) Make a list of your short term (3mo), mid term (6mo) and long term (12mo) goals you would like to achieve regarding your health and include personal goals in this as well (relationship, financial, career, hobbies, etc.). Keep a copy of this.**

After you do these things you will be ready for your visit with us! We are looking forward to meeting you and desire to make a difference in your life and we know you will make a difference in ours. We understand that this is a lot of paperwork for you to fill out but we want you to get the most out of your visit with us and this will assist us and you greatly.

A map is enclosed so you will be able to find our facility. If you have any trouble locating us please give us a call and we will be glad to assist you. Be sure you bring all the paperwork with you and arrive 30 minutes before your scheduled appointment time. If you arrive without your paperwork we will not be able to see you and you will be charged 80% of the visit for that day. You will not have time to fill out the paperwork in our office due to the complexity of it. However if you misplace this packet you can arrive 1 ½ hours early and fill out a packet in our facility.

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We try to keep everything running smoothly in our facility and create a healing environment for everyone so we thank you for your patience with our guidelines. Occasionally we do run behind schedule due to the complex nature of what we do but rest assured, you will always get the same careful attention to your needs as the patient before you.

Please remember that we do not bill insurance companies for our services but we will give you a descriptive bill that you can submit to your insurance company for possible reimbursement. If you are a Medicare beneficiary you will not be able to bill Medicare for any reimbursement of our services. On your first visit we only accept cash, credit card or money order as a form of payment. After you are established with us we will be glad to accept your personal check if your account is in the United States.

Please remember our 48 hour cancellation policy. If you do not show up for your visit or if you cancel after the 48 hour mark then you will be charged 80% of your scheduled visit fee. We do set aside a huge block of time to see you so you can understand that it can be a real inconvenience if you do not show up or allow us time to fill that place with someone else who may need the care.

Thank you for choosing Quantum Healing Institute for your healthcare needs. We are excited to be able to serve you. Be prepared to stay with us for about three hours and we will do everything we can to make it a magical experience for you.

Have a Blessed day and LIVE WITH PASSION!!!!

Sincerely,

A handwritten signature in black ink that reads "C. deWet". The signature is written in a cursive, flowing style.

**Cindi de Wet
Quantum director**



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Commitment to Excellence

Here at Quantum Healing Institute, it is our commitment to provide you with a very high standard of care blended with love, compassion and integrity. It is so important to us that you get the care you desire and deserve here at our facility.

The commitment we need from you is that you will keep your appointments when you make them. We understand that emergencies arise but they are few and far between in normal circumstances. We need to know that if you make an appointment with Dr. Pieter or Cindi deWet, you are committed to keeping that appointment or paying for the time space you selected if you cannot make it or give a 48 hour notification. If you give proper notification then it is not a problem but often times people will just simply forget or not show up due to other important things going on and leave the doctor hanging. He is committed to being here for you and so is the staff, so please keep your commitment as well.

*Gratefully,
QHI*

Signature: _____ Date: _____

"Often what we call thinking is merely recycling the opinions of others"



NEW PATIENT'S MEDICAL INFORMATION PACKET

PATIENT INFORMATION

Name:(First) _____ (MI) _____ Last _____
Date of Birth: _____ Age: _____ Sex ___M ___F Marital Status S M W D
Address: Street _____
City _____ State _____ ZIP _____
Phone # _____ Cell Phone # _____
Social Security# _____ Driver's License# _____
Work# _____ Employer: _____
Employer's Address _____
Referring Physician: _____ If Student, School Name: _____ Full/Part Time: _____
Referred by: _____ E-mail address: _____

RESPONSIBLE PARTY OR SPOUSE INFORMATION

Name: _____ Relationship to Patient: _____
Address: _____
(Street) _____
(City, State, ZIP) _____
Phone # _____ Social Security # _____ Driver's License # _____
Work # _____
Employer: _____
Employer's Address: _____

Friend or Relative Not Living With You: _____ Phone # _____

I have read the policies of Quantum Healing Institute and agree to abide by them. I understand that I am fully responsible for any charges that I incur in full at the time of service. I understand that Quantum Healing Institute will not bill my insurance for me. Dr. de Wet is not considered an insurance provider and insurance companies may not cover any services provided or ordered by our office. Medicare will not cover in office services, but may cover costs for services ordered outside this clinic such as labs or other diagnostic testing. Other Insurance companies may or may not reimburse you for some services in our office. We do not guarantee or claim that any insurance company will reimburse anything done by our office.

Patient's
Signature _____ Date _____

"No one owes me the fulfillment of my own wishes"



Please take the time to complete this survey. It is intended to establish a number of basic health facts which are important to the analysis of your problem(s) and to gain a comprehensive picture of your health. It is also intended to insure that as much time as possible will be spent discussing health problems that concern you. It is not intended to substitute for a personal interview.

Today's Date: _____

Primary Physician: _____

Please give a brief history of your current problems.

MEDICAL HISTORY

Please check the appropriate box if you have any of the following:

cataracts	_____	glaucoma	_____
other eye disease	_____	hay fever	_____
asthma	_____	chronic hives	_____
pneumonia	_____	chronic bronchitis	_____
emphysema	_____	high blood pressure	_____
heart disease	_____	tuberculosis	_____
circulatory problem	_____	varicose veins	_____
phlebitis	_____	ulcers	_____
gastrointestinal bleeding	_____	colitis	_____
hemorrhoids	_____	cirrhosis of the liver	_____
gallstones	_____	pancreatitis	_____
kidney infections	_____	kidney stones	_____
prostate trouble	_____	hernia	_____
pregnancies	_____	anemia	_____
bleeding disorder	_____	blood transfusion	_____
diabetes	_____	thyroid disease	_____
high lipids-cholesterol	_____	arthritis	_____
cancer	_____	gout	_____
epilepsy	_____	stroke	_____
concussion	_____	meningitis	_____
severe depression	_____	drug abuse	_____
HIV	_____	psychiatric disease	_____
involuntary Urine Loss	_____		

"We must become what we wish to teach"



Infections (Check the illnesses you have had)

Measles _____	Mumps _____	Whooping Cough _____
Scarlet Fever _____	Typhoid Fever _____	Chicken Pox _____
Mononucleosis _____	Rheumatic Fever _____	Nephritis _____
Hepatitis _____	Venereal Disease _____	
	(Gonorrhea, Syphilis) _____	

Injuries

Date	Type of Injury	Reason	Hospital

Surgery

Date	Type of Surgery	Reason	Hospital

Hospitalizations (other than for surgery)

Date	Reason	Hospital

Immunizations – Indicate the date of your last booster.

Diphtheria, Tetanus	<u>Date</u>	_____	Measles, Mumps, Rubella	<u>Date</u>	_____
Flu Shot	_____		Pneumonia Shot	_____	
Small Pox	_____		Oral Polio	_____	
TB Skin Test	_____				

"My life does not belong to others and I am not here to live up to someone else's expectations"



Diagnostic Procedures - Indicate if and when you have had any of the following.

	<u>YES</u>	<u>DATE</u>		<u>YES</u>	<u>DATE</u>
Dental procedures	_____	_____	EKG	_____	_____
Heart Catheterization	_____	_____	Stress Test	_____	_____
Chest X-ray	_____	_____	Mammogram	_____	_____
Kidney X-ray (IVP)	_____	_____	Lung Function	_____	_____
Gallbladder X-ray	_____	_____	GI Series	_____	_____
Colon X-ray	_____	_____	Colonoscopy	_____	_____
Upper Endoscopy	_____	_____	Proctoscopy	_____	_____
Stool blood test	_____	_____	Pap Smear	_____	_____
P.S.A. (Prostate Specific Antigen- male)	_____	_____	HIV	_____	_____

Allergies – List medications you cannot take and the problems it causes.

<u>Medication</u>	<u>Reaction</u>

List your current medications.

<u>Medication</u>	<u>Reason</u>
a. Regular Medications:	
b. Medications taken as needed:	
c. Vitamins & Non-prescription medications:	

"Relaxation implies that we are not hiding from ourselves and are not at war with who we are"



FAMILY HISTORY

Have any of the following diseases been diagnosed in a blood family relative:

	<u>Parent or Grandparent</u>	<u>Sister or Brother</u>	<u>Children</u>
Cancer	_____	_____	_____
Heart Trouble	_____	_____	_____
Stroke	_____	_____	_____
High Blood Pressure	_____	_____	_____
Diabetes	_____	_____	_____
Kidney Disease	_____	_____	_____
Tuberculosis	_____	_____	_____
Arthritis	_____	_____	_____
Mental Illness	_____	_____	_____
Blood Disorders	_____	_____	_____
Epilepsy	_____	_____	_____
Glaucoma	_____	_____	_____
Gout	_____	_____	_____
Stomach Ulcers	_____	_____	_____

SOCIAL HISTORY

Habits _____

Do you follow a particular diet?

If so, for what reason? _____

Do you drink coffee or hot tea?

If so, how many cups a day? _____

Do you exercise regularly?

If so, how often? _____

Have you ever smoked?

If so, how much (packs per day)? _____

How long? _____

When did you quit? _____

Do you drink alcoholic beverages? _____

If so, how many beers or drinks in an average day? _____

Were you a heavy drinker in the past? _____



Occupation

- a. **What kind of work do you do?** _____
- b. **How long have you done this kind of work?** _____
- c. **Are you satisfied with your work?** _____
- d. **What other kinds of work have you done?** _____
- e. **Are you aware of any hazardous exposures associated with your present or past jobs?**

- f. **Have you ever changed jobs for health reasons?** _____
- g. **Were you in the military? If so, How Long?** _____
Were you medically retired? _____
Were you refused entry into active duty for health reasons? _____
- h. **Have you received Workers' Compensation or other Disability?** _____

Personal

- a. **Are you -** married _____ single _____ separated _____ divorced _____ widowed _____
- b. **How many years education did you complete?**
grade school _____ high school _____
college _____ professional _____
technical, business _____
- c. **What kind of hobbies do you enjoy?** _____
- d. **Where were you born?** _____
- e. **Where else have you lived?** _____



REVIEW OF SYSTEMS

Please check any of the following problems that you now have or have recently had.

General Symptoms:

- Weight loss or gain without dieting _____
- Fever _____
- Chills _____
- Night sweats _____
- Feeling "run down" or tire easily _____
- Involuntary urine loss _____

Do you wear glasses or contact lenses _____

Have you had:

- Serious loss of vision in either eye _____
- Double vision _____
- ringing or buzzing in ears _____
- Ear infections _____
- Dizziness or spinning _____
- Loss of hearing _____
- Frequent sore throat _____
- Persistent hoarseness or problems with vocal cords _____
- Lumps or swelling in neck _____

CHEST:

- Persistent cough _____
- Coughing up blood _____
- Shortness of breath with exertion _____
- Shortness of breath at rest _____
- Shortness of breath in bed at night _____
- Wheezing _____

CARDIOVASCULAR:

- Chest pain or discomfort on exertion _____ or at rest _____
- Irregular heart beat or palpitations _____
- Other conditions (specify _____)

"When we fight a feeling it grows stronger. When we acknowledge, experience and accept it, it begins to melt away"



GASTROINTESTINAL:

- Difficult swallowing _____
 - Nausea _____
 - Vomiting _____
 - Constipation _____
 - Diarrhea _____
 - Vomiting blood _____
 - Hiatal hernia _____
 - Blood, tarry-looking bowel movements _____
 - Hemorrhoids _____
 - Colic or abdominal pain _____
 - Heartburn _____

 - Other conditions (ex: cancer) _____
-

KIDNEY:

- Pain or burning on urination _____
- Blood in urine _____
- Difficulty in starting stream _____
- Dribbling at end of stream _____

- Other conditions (ex: involuntary urine loss, etc. _____)

BONES, JOINTS AND MUSCLES:

- Joint pain swelling or stiffness _____
- Back brace or other orthopedic appliance _____

- Other conditions (specify _____)

SKIN DISORDERS:

- Eczema or other rashes _____
- Hives _____
- Skin cancers _____
- Recent changes in moles _____

- Other conditions (specify _____)

"Fear and pain should be treated as signals not to close our eyes but to open them wider"



NEUROLOGICAL:

- Paralysis or weakness of any part _____
- Frequent headaches _____
- Dizziness _____
- Confusion _____
- Irritability, anxiety _____
- Numbness of skin _____
- Weakness of muscles _____

ENDOCRINE AND METABOLIC:

- Excessive hunger or thirst _____
- Bothered by hot or cold weather _____

BLOOD:

- Blood transfusions _____
- Easy bruising or bleeding gums _____
- Lymph node enlargement
(swollen glands currently) _____

Other conditions (specify _____)

PSYCHIATRIC:

- Difficulty sleeping _____
- Feelings of depression or sadness _____
- Loss of interest in sex or hobbies _____
- Thoughts of suicide _____
- Difficulty concentrating _____
- Feelings of guilt or worthlessness _____
- Excessive fatigue _____
- Changes in appetite _____

FOR WOMEN ONLY (MEN SKIP TO BOTTOM OF NEXT PAGE)

MENSTRUAL HISTORY:

- Age of onset of menstruation _____
- Date last menstrual period began _____
- Length of period _____ days
- Irregular periods _____
- Bleeding between periods _____
- Unusually heavy periods _____
- Severe menstrual cramps _____
- If periods have stopped: _____ at what age _____

"Your repeated thoughts become your reality"



PREGNANCY:

Do you use birth control? _____
Are you currently pregnant? _____
Number of pregnancies _____
Number of living children _____
Number of miscarriages, stillborns
or abortions _____
High blood pressure during pregnancy _____
Diabetes during pregnancy _____

BREAST:

Lumps or discharge _____
Pain _____
Breast cancer (specify _____)
Other conditions (specify _____)

FOR MEN ONLY:

Pain or swelling of testicles _____
Enlarged prostate _____
Prostate cancer _____
Difficulty with erections _____
Involuntary Urine Loss _____

"Life can only be understood backwards but it must be lived forwards"



AUTHORIZATION TO TREAT

I, the undersigned patient, hereby authorize Dr. Pieter J. deWet (and appointed staff) to administer such treatment as is necessary, and to perform services and / or procedures as are considered necessary on the basis of findings during the course of said treatment.

I hereby certify that I have read and fully understand the above Authorization To Treat, the reasons why the treatment is considered necessary, its advantages and possible complications, if any, as well as possible alternative modes of treatment which are explained to me.

I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Patient's Signature

Date

Guardian's Signature

Relationship

Witness Signature

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"People are lonely because they build walls instead of bridges"



I, _____, understand that I have sought advice and care from Quantum Healing Institute and I clearly understand that this facility and all its providers and affiliates can only advise me and guide me in my health care options. I am responsible for the decision making of my health and the choices I make with regards to treatment at this facility. I am of sound mind and I take full responsibility for the treatment choices I make and understand that I have free choice to do or not to do anything that has been suggested to me or advised. I do not hold Quantum Healing Institute or its providers or staff accountable or responsible for my health and I agree to be responsible for my own health and to educate myself fully on every idea or suggestion presented to me and to educate myself on my health conditions or challenges that I may be faced with throughout my care as well as educate myself on all the risks involved.

I agree that I do not have to do or will not do anything I am uncomfortable with or unsure about and I will take responsibility for asking questions, researching all options and seeking education and knowledge elsewhere including from my primary physician if I choose to and that Quantum Healing Institute always encourages participation of my primary physician.

Patient name (printed) : _____

Signature: _____ Date: _____

Guardian signature if for minor: _____

Guardian name (printed): _____

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"Only one person in the world can defeat you. That is yourself!"



MEDICAL BILLS RESPONSIBILITY

Date: _____

Patient Name: _____ **DOB:** _____

I understand that I have sought care and guidance from Quantum Healing Institute and its' staff. I understand that I am fully responsible for all charges incurred at this facility at the time of service and any other charges related to my care such as records reviews, records copies or phone consults, etc. I understand that this facility does not file insurance for me. Dr. de Wet is not considered an insurance provider with insurance companies and they may not cover any services provided or ordered by our office. Medicare definitely will not cover services provided by this facility and are not to be billed for any reimbursement.

Signed: _____ **Date:** _____

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Medical Records Department

HIPPA: Authorization to Use or Disclose Protected Health Information (to Quantum Healing Institute)

AUTHORIZATION FOR RELEASE OF INFORMATION

NAME: _____

I hereby authorize and request _____ (Provider) (ph: _____ fax: _____) to provide to Quantum Healing Institute (Pieter J. deWet, M.D.) copies of record information. The information to be disclosed is Medical Records for the purpose of evaluation and care.

This authorization expires: _____

I understand that I may revoke this authorization in writing at any time by providing the "Provider" with written notice of my decision to revoke this authorization. I understand that the "Provider" is unable to take back any disclosures it has made upon this authorization as stated in the "Provider's" Notice of Privacy Practices. I further understand that if I do not revoke this authorization, it will remain in effect until the expiration date above.

I understand that it is possible that the information to be used or disclosed may be subject to re-disclosure by the receiving party and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996. I further understand that treatment, payment or enrollment or eligibility for benefits cannot be conditioned on whether I sign this authorization except that research-related treatment may be conditioned on an authorization that permits the use of PHI for such research.

I understand that the specific information to be disclosed may include history of or treatment of DRUG or ALCOHOL ABUSE; history of or treatment of MENTAL HEALTH CONDITIONS; or history of, testing for or treatment for, ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS OR RELATED CONDITIONS). I further understand that this consent is subject to revocation at any time in the form of written notice from me, except to the extent that action has been taken in reliance thereon, or without revocation, will expire _____ days from the date below.

Patient's Printed Name

Signature, Other Than Patient

Date of Birth

Social Security No.

Relationship to Patient

Date Signed

Witnessed Signature

Patient's Signature
Any Disclosure Of Medical Record Information By The Recipient is Prohibited.

Physician Requesting Information
Any Disclosure Of Medical Record Information By The Recipient is Prohibited.

Quantum Healing Institute Location

