

CLIENT INFORMATION AND STATEMENT

* REQUIRED

*COMPLETE NAME: _____ *SPOUSE: _____

*(FOR CLIENTS UNDER 18 YEARS OF AGE) FATHER: _____ MOTHER: _____

*PHYSICAL STREET ADDRESS: _____
(UPS WILL NOT SHIP TO A PO BOX)

*CITY: _____ *COUNTY: _____ *STATE: _____ *ZIP: _____

*DAY TIME PHONE: HOME: _____ WORK: _____ FAX: _____
(EASILY REACHED BETWEEN 8 AM - 5 PM EST)

CELL: _____ E-MAIL ADDRESS: _____

HEALTH INFORMATION

1. HAVE YOU EVER HAD OR BEEN DIAGNOSED AS HAVING PROBLEMS WITH ANY OF THE FOLLOWING?

<input type="checkbox"/> ANEMIA	<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> DIGESTION	<input type="checkbox"/> CIRCULATION	<input type="checkbox"/> LIVER
<input type="checkbox"/> DIABETES	<input type="checkbox"/> KIDNEYS	<input type="checkbox"/> LUNGS	<input type="checkbox"/> STOMACH	<input type="checkbox"/> CANCER
<input type="checkbox"/> HEART	<input type="checkbox"/> FAINTING	<input type="checkbox"/> BLEEDING	<input type="checkbox"/> HIGH BLOOD PRES.	<input type="checkbox"/> HEARING LOSS
<input type="checkbox"/> PROSTATE	<input type="checkbox"/> HYPOGLYCEMIA	<input type="checkbox"/> PMS	<input type="checkbox"/> ALZHEIMER'S	<input type="checkbox"/> SLOW LEARNER
<input type="checkbox"/> NERVES	<input type="checkbox"/> OVARIES	<input type="checkbox"/> ASTHMA	<input type="checkbox"/> HAY FEVER	<input type="checkbox"/> EYE PROBLEMS
<input type="checkbox"/> THYROID	<input type="checkbox"/> THROAT	<input type="checkbox"/> EPILEPSY	<input type="checkbox"/> HEMORRHOIDS	<input type="checkbox"/> SPLEEN
<input type="checkbox"/> SKIN	<input type="checkbox"/> BREAST	<input type="checkbox"/> COLON	<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> WEIGHT
<input type="checkbox"/> GALL BLADDER	<input type="checkbox"/> BLADDER	<input type="checkbox"/> SPINE/BACK	<input type="checkbox"/> PARASITES	<input type="checkbox"/> EDEMA
<input type="checkbox"/> TUMORS	<input type="checkbox"/> PANCREAS	<input type="checkbox"/> OTHER PROBLEMS		

2. OCCUPATION: _____ *DATE OF BIRTH: _____

3. ARE YOU ALLERGIC TO ANY FOOD OR MEDICATION? _____

4. ARE YOU PREGNANT? _____ IF SO, NUMBER OF MONTHS: _____

5. ARE YOU UNDER A LOT OF STRESS? _____ DESCRIBE: _____

6. WHAT CONDITIONS ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE FOR? _____

7. PLEASE LIST ANY MEDICATIONS YOU ARE TAKING: _____

8. WHO TOLD YOU ABOUT OUR SERVICES? GIVE COMPLETE NAME(S): _____

9. DO YOU HAVE A PACEMAKER FOR YOUR HEART? _____ BLOOD TYPE: _____

CLIENT STATEMENT

I UNDERSTAND THAT I AM HERE TO LEARN ABOUT NUTRITION AND BETTER HEALTH PRACTICES AND THAT I WILL BE OFFERED INFORMATION ABOUT FOOD SUPPLEMENTS AND HERBS AS A GUIDE TO GENERAL GOOD HEALTH AND THIS IS CONSIDERED A PERSONAL MINISTRY AND SPIRITUAL COUNSELING SERVICE. I UNDERSTAND THAT I AM TAKING FULL RESPONSIBILITY FOR ALL DECISIONS CONCERNING MY HEALTH AND HEREBY RELEASE OVERMAN'S HEALTHY CHOICES, A PRIVATE HEALTHCARE MEMBERSHIP ASSOCIATION AND ALL THEIR EMPLOYEES FROM ANY LIABILITY WHATSOEVER.

I FULLY UNDERSTAND THAT THOSE WHO COUNSEL ME ARE NOT MEDICAL DOCTORS OR PRACTITIONERS AND I AM NOT HERE FOR MEDICAL DIAGNOSTIC PURPOSES OR TREATMENT PROCEDURES. I AM NOT ON THIS VISIT OR ANY SUBSEQUENT VISIT AN AGENT FOR FEDERAL, STATE OR LOCAL AGENCIES OR ON A MISSION OF ENTRAPMENT OR INVESTIGATION.

THE SERVICES PERFORMED BY JAMES OVERMAN AND/OR OTHERS AT THIS LOCATION ARE AT ALL TIMES RESTRICTED TO THE SUBJECT OF NUTRITIONAL MATTERS INTENDED FOR THE MAINTENANCE OF THE BEST POSSIBLE STATE OF NUTRITIONAL HEALTH AND DO NOT INVOLVE THE DIAGNOSING, TREATMENT OR PRESCRIBING OF REMEDIES FOR DISEASE.

I UNDERSTAND THAT ZAPPERS HAVE BEEN DEMONSTRATED BY RESEARCHERS TO KILL SOME PARASITES; THAT ZAPPERS HAVE NOT BEEN APPROVED BY THE AMA FOR USE ON HUMANS; THAT NO MEDICAL CLAIMS ARE MADE OR IMPLIED BY THE MANUFACTURER OR BY THE OVERMANS OR THEIR EMPLOYEES; THAT ZAPPERS SHOULD NOT BE USED BY PREGNANT WOMEN OR PEOPLE WITH PACEMAKERS; THAT THE USE OF ZAPPERS AND OTHER EQUIPMENT ARE LOANED WITHOUT CHARGE FOR RESEARCH ONLY FOR MY VOLUNTARY USE AT MY OWN RISK.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENT

*SIGNATURE OF CLIENT (PARENT IF UNDER 18 YEARS OF AGE): _____ DATE: _____

OVERMAN'S HEALTHY CHOICES
(A Private Healthcare Membership Association)
MEMBERSHIP CONTRACT

I, _____, for membership fee paid in hand, do hereby apply for membership in Overman's Healthy Choices, a private healthcare membership organization. With the signing of this membership agreement I/we accept the offer made to become a member of Overman's Healthy Choices and have read and agree with the following Declaration of Purpose from Article I of Overman's Healthy Choices Articles of Association.

1. This Association of members hereby declares that our main objective is to protect our rights to freedom of choice regarding our healthcare information and care, through maintaining our Constitutional rights.

2. As members, we affirm our belief that the Constitution of the United States is one of the best documents ever devised by man and the signers of the Declaration of Independence did so out of love for their country. We believe that the First Amendment of the Constitution of the United States of America guarantees our members the rights of free speech, petition, assembly, and the right to gather together for the lawful purpose of advising and helping one another in asserting our rights under the Federal and State Constitutions and Statutes. We strive to maintain and improve the civil rights, constitutional guarantees, and freedom of choice in medical care and political freedom of every member and citizen of the United States of America.

3. We declare the basic right of all of our members to select spokesmen from our number who could be expected to give wisest counsel and advice concerning the need for physical and mental health care assistance and to select from our membership those members who are the most skilled to assist and facilitate the actual performance and delivery of therapy, treatment and care.

4. We proclaim the freedom to choose and perform for ourselves the types of therapies and treatment modalities that we think best for assessing, treating and preventing illness and disease of our minds and bodies and for achieving and maintaining optimum wellness. We proclaim and reserve the right to include medical and health options that include, but are not limited to, cutting edge treatment modalities and therapies practiced or used by any type of healers or therapists or practitioners the world over, whether traditional or nontraditional, conventional or unconventional.

5. More specifically, the mission of our Association is to provide members with the highest level of quality care and the most effective methods of treatment. We treat members and their health condition, and not merely the symptoms experienced. Our Association understands that wellness has many dimensions and strives every day to stay on the leading edge of new technology. The Association provides comprehensive, conventional, complementary alternative care and the most advanced technologies to assess all aspects of a member's disease and/or health and provide the most effective means of treatment at an affordable fee. More specifically, the Association specializes in environmental, longevity, anti-aging, holistic and nutritional alternates as well as the use of electronic instruments, subtle energy devices and herbal products as alternates to medication concerning the modalities of service and benefits to members.

6. The Association will recognize any person (irrespective of race, color, or religion) who is in accordance with these principles and policies as a member, and will provide a medium through which its individual members may associate for actuating and bringing to fruition the purposes theretofore declared.

MEMORANDUM OF UNDERSTANDING

I understand that the fellow members of the Association that provide health assessment, therapy, treatment and care, etc. do so in the capacity of a fellow member and not in the capacity as a licensed health care provider. I further understand that within the association no doctor-patient relationship exists but only a contract member-member Association relationship. In addition, I have freely chosen to change my legal status as a public patient to a private member of the Association. I further understand that it is entirely my own responsibility to consider the advice and recommendations offered to me by my fellow members and to educate myself as to the efficacy, risks and desirability of same and the acceptance of the offered or recommended health assessment, therapy, treatment and care, etc. is my own carefully considered decision. Any request by me to a fellow member to assist me or provide me with the aforementioned health assessment, therapy, treatment and care, etc. is my own free decision in an exercise of my rights and made by me for my benefit and I agree to hold the Trustee(s), staff and other worker members and the Association harmless from any unintentional

liability for the results of such care, etc., except for harm that results from instances of a clear and present danger of substantive evil as determined by the Association, as stated and defined by the United States Supreme Court.

The Trustee and members have chosen Dr. James R. Overman as the person best qualified to perform healthcare services to members of the Association and entrust him to select other members to assist him in carrying out that service.

In addition, I understand that since the Association is protected by the First and Fourteenth Amendments to the U.S. Constitution, it is outside the jurisdiction and authority of Federal and State Agencies and Authorities concerning any and all complaints or grievances against the Association, any Trustee(s), members or other staff persons. All rights of complaints or grievances will be settled by an Association Committee and will be waived by the member for the benefit of the Association and its members. Because the privacy and security of healthcare membership records maintained within the Association have been held to be inviolate by the U.S. Supreme Court, the undersigned member waives HIPAA privacy rights and complaint process. Healthcare records kept by the association will be strictly protected and **only** released upon written request of the member. I agree that violation of any waivers in this membership contract will result in a no contest legal proceeding against me. In addition, the Association does not participate in any medical insurance plans or collections on behalf of the member, but will provide a suitable invoice for the member to pursue reimbursement by his/her insurance company, if applicable.

I agree to join the Association, a private membership association under common law, whose members seek to help each other achieve better health and live longer with good quality of life.

I understand that the doctors, nurses and other providers who are fellow members of the Association are offering me advice, services and benefits that do not necessarily conform to conventional medical care. I do not expect these benefits to include on-call coverage, hospital care or the usual and customary care provided by most physicians. I will receive such primary and specialist care elsewhere. I fully understand that the benefits I receive from Association might or might not be covered by my health insurance and not at all by Medicare.

As a member, I accept the goals of helping my body function better and choosing techniques that are both very safe and have a reasonably good chance to succeed, realizing that no diagnostic technique or treatment is foolproof. If I choose to forego drugs, surgery or radiation that has been recommended to me by others, I fully accept the risk that I might suffer serious consequences from that choice. Other aspects of informed consent will take place in my discussions with the providers and my fellow members of the Association.

My activities within the Association are a private matter that I refuse to share with the State Medical Board, the FDA, Medicare, Medicaid or my own insurance company without my expressed specific permission. All records and documents remain as property of the Association, even if I receive a copy of them. I fully agree not to file a malpractice lawsuit against a fellow member of the Association, unless that member has exposed me to a clear and present danger of substantive evil. I acknowledge that the members of the Association do not carry malpractice insurance.

I enter into this agreement of my own free will or on behalf of my dependent without any pressure or promise of cure. I affirm that I do not represent any state or federal agency whose purpose is to regulate the practice of medicine. I have read and understood this document, and my questions have been answered fully to my satisfaction. I understand that I can withdraw from this agreement and terminate my membership in this association at any time. These pages and Article I of the Articles of Association of the Association consist of the entire agreement for my membership in the Association, and they supersede any previous agreement.

I understand that the membership fee entitles me to receive those benefits declared by the Trustee(s) to be "general benefits" free of further charge. I agree to pay as levied those benefits that I receive that are declared by the Trustees to be "special assessments", per Fee Schedule.

I agree to the charge of \$10.00 as consideration for my lifetime membership contract, said term beginning with the date of the signing of this contract, and by these presents do hereby certify, attest and warrant that I have carefully read the above and foregoing Overman's Healthy Choice Contractual Application for Membership, and I fully understand and agree with same.

IN WITNESS WHEREOF I set my hand this _____ day of _____, 20____.

Member's Name (Please Print Legibly) **(...and name of legal guardian if applicant under 18 years)**

Member's Signature **(and signature of legal guardian if applicant under 18 years)**

Members Address and Phone #:

Street

Apt. # _____

Code City State Zip

Home Phone #

Work Phone #

Cell Phone #

OVERMAN'S HEALTHY CHOICES

By _____

Approved and accepted this _____ day of _____, 20____.