

TRANSFORM YOUR HEALTH

Patient Application

Patient Name: _____	
Address: Street: _____	
City: _____ State: _____ Zip: _____	
Home Phone: _____ Mobile Phone: _____ E-Mail: _____	
SSN: _____	
Does patient have regular access to the Internet? _____ Yes _____ No	
Medical Info: DOB: _____ Weight: _____ BP: _____ / _____ Cholesterol: _____ Triglycerides: _____ HDL/LDL: _____	Does the patient currently suffer from: _____ Diabetes _____ Heart Disease _____ Hypertension _____ Stroke _____ Arthritis
Is the patient currently taking medication for any of these conditions? _____ Yes _____ No	
Please list them: _____ Attach list and fax if multiple medications	
Is the patient regularly physically active? _____ Yes _____ No	
How many days a week? _____ For how many minutes each time? _____	
Billing Info:	Credit Card Type: _____ Visa _____ MC
Card number: _____	
Expiration: (MM/YY): _____	
Name On Card: _____	
Billing address (if different from above):	
Address: Street: _____	
City: _____ State: _____ Zip: _____	
<i>I understand that this is a minimum 12 week commitment to establish a lifestyle of personal health. This program is not medical care or medical treatment. It is not meant for the diagnosis or treatment of any disease. I will commence this program with the full supervision of my personal physician. I agree to an initial program payment of \$595 for the first month, and between \$130 and \$240 a month following billed to this credit card which covers all costs associated with the "Transform Your Health" program. I understand that I may cancel the program at any time with five days notice, but that all costs up to and following five days from that notice are non-refundable.</i>	
Patient Signature: _____ Date: _____	

Please Fax the Completed Form to: (303) 484-4973
Qi Kinesis Athletic Club