DYNAMIC HEALTH
A Private Membership Healthcare Association

2065 Riverstone Dr. Suite 102
Coeur d'Alene, ID 83814
208-765-8061

# Personal Information

Date_____ ☐ Male ☐ Female

Name of person needing care: Last: _____ First _____

Preferred First Name _____

Date of Birth_____ Age_____

Mailing Address _____

City_____State_____Zip_____

Home Phone_____ Cell Phone _____ Email _____

Occupation _____ Employer _____ Employer Phone _____

Marital Status: M S W D Name of Spouse _____

Name and Ages of Dependent Children _____

_____

Emergency Contact _____ Phone _____ Relationship _____

Whom may we thank for referring you? _____

Would you like Dr. Smith to pray for you before your treatment? Yes _____ No thanks _____

Signature _____ Date _____

***If person needing care is a minor:***

I _____ being the parent / guardian of _____ do hereby consent, authorize and request Dynamic Health to administer such treatment deemed advisable, necessary or requested on the above minor. I agree to hold the doctor free and harmless from any claims, suits for damages or complication that may result from such treatment. I am aware that I will be responsible for the balance due of the services that are provided.

Signed: _____ Date: _____

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# Possible Lyme Disease Symptoms

***Name*** _____ ***Date*** _____

*This checklist is provided to streamline your consultation, and to establish a baseline for your progression of healing.*

**Have you experienced any of the following in relation to this illness?**

| | | | | | |
|---|---|---|---|---|---|
| Tick bite | ❑ Yes | ❑ No | Linear, red streaks | ❑ Yes | ❑ No |
| "Bullseye" rash (discrete red circle) | ❑ Yes | ❑ No | Positive ELISA or Western Blot | ❑ Yes | ❑ No |
| Spotted rash over large area | ❑ Yes | ❑ No | | | |

| SYMPTOM OR SIGN | CURRENT SEVERITY | | | CURRENT FREQUENCY | | |
|---|---|---|---|---|---|---|
| *Check all that apply:* | MILD | MODERATE | SEVERE | OCCASIONAL | OFTEN | CONSTANT |
| Persistent swollen glands | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sore throat | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Fevers | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sore soles of the feet, especially in the morning | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Pain in fingers | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Pain in toes | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Pain in ankles | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Pain in wrists | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Pain in knees | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Pain in elbows | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Pain in hips | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Pain in shoulders | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Swelling of fingers | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Swelling of toes | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Swelling of ankles | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Swelling of wrists | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Swelling of knees | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Swelling of elbows | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Swelling of hips | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Swelling of shoulders | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Unexplained back pain | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Stiffness of the joints or back | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Muscle aches or cramps | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Obvious muscle weakness | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Twitching of the face or other muscles | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Confusion, difficulty thinking | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Problems with concentration or reading | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Problems absorbing new information | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Word search, "name block" | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Forgetfulness, poor short term memory, poor attention | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Disorientation: getting lost, going to the wrong places | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Speech errors: using the wrong word or misspeaking | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Mood swings, irritability, depression | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Anxiety, panic attacks | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Psychosis (hallucinations, delusions, paranoia, bipolar) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Tremors | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

# Possible Lyme Disease Symptoms

| SYMPTOM OR SIGN | CURRENT SEVERITY | | | CURRENT FREQUENCY | | |
|---|---|---|---|---|---|---|
| *Check all that apply:* | MILD | MODERATE | SEVERE | OCCASIONAL | OFTEN | CONSTANT |
| Seizures | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Headaches | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Abnormally sensitive to light | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Abnormally sensitive to sound | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Double vision, blurry vision, or "floaters" | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Ear pain | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Buzzing or ringing in ears, decreased hearing | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Increased motion sickness, vertigo, spinning sensation | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Off balance "tippy" feeling | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Lightheadedness, wooziness, unavoidable need to sit or lie down | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Tingling, numbness or burning sensations / shooting pains / skin hypersensitivity | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Facial paralysis - Bell's Palsy | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Unexplained tooth or gum pain | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Neck creaking or cracking, neck stiffness, neck pain | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Fatigue, tired, poor stamina | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Insomnia, interrupted sleep, early awakening | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Excessive night time sleep | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Napping during the day | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Unexplained weight gain | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Unexplained weight loss | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Pain in genital area | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Unexplained menstrual irregularity | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Unexplained milk production or breast pain | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Irritable bladder or bladder dysfunction | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Erectile dysfunction | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Loss of libido | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Queasy stomach or nausea | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Heartburn or stomach pain | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Constipation | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diarrhea | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Low abdominal pain or cramps | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Heart murmur or valve prolapse | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Heart palpitations or skips | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| "heart block" on EKG | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Chest wall pain or sore ribs | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sinus congestion | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Breathlessness, "air hunger", unexplained chronic cough | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Profuse sweating at night | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| The feeling of "slowly dying" or premature aging | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| "Brain Fog" | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Symptoms that are gradually getting worse | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

***Lyme Disease can cause any of the symptoms listed above. You may have just a few of them, or many of them. The severity of your symptoms are directly related to the amount of Lyme infections you have, and how well your immune system is dealing with them.***

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# Symptom Survey

***Name*** _____ ***Date*** _____

PLEASE PRINT and **CIRCLE** any appropriate responses.

Please describe your **three most significant symptoms** (use other side if necessary): _____

_____

_____

_____

_____

_____

_____

How long have you had these symptoms? _____

Are your symptoms: ***mild*** ***moderate*** ***severe***

Are your symptoms getting: ***better*** ***worse*** ***no change***

What doctor(s) have you seen for these symptoms? _____

_____

_____

What doctor-recommended treatment(s) have you had in the past? _____

_____

_____

_____

Were they effective? ***No*** ***Yes*** ***If yes, which one(s)?*** _____

_____

Please list all over-the-counter and prescription medications that you are taking and what they are used for (use other side if necessary): _____

_____

_____

_____

_____

_____

Have you ever had a life-threatening allergic reaction? ***No*** ***Yes, to what?*** _____

Please rate your overall energy level: ***poor*** ***fair*** ***good*** ***excellent***

Please rate your overall physical health: ***poor*** ***fair*** ***good*** ***excellent***

Please rate your current stress level: ***normal*** ***high*** ***intolerable***

***Name*** _____ ***Date*** _____

PLEASE PRINT and **CIRCLE** any appropriate responses.

- Do you have: ***asthma sneezing sinusitis watery-itchy-swollen eyes N/A***
- Do fragrances, chemical odors, or second-hand smoke irritate your sinuses or lungs? ***Yes No***
- Do you get: ***skin rashes itching hives eczema headaches N/A***
- Do you take antacids or acid blocking medication? ***Yes No***
- Please list any food or beverages that seem to cause any unpleasant symptoms:_____

_____

_____

- What specific food items do you frequently eat for breakfast, lunch, dinner or snacking? _____

_____

_____

- Which of these do you drink on a regular basis?

***coffee tea milk fruit juice soda diet soda beer wine soy milk rice milk other*** _____

- How much per day? _____
- Do you have any root canals? ***Yes No If so, how many?*** _____
- Are you wearing a pacemaker? ***Yes No***
- How are your symptoms affecting the quality of your life? _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

- What are your expectations of your treatment with us? _____

_____

_____

_____

_____

_____

_____

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# Office Procedures and Fees

***Thank you for choosing LymeStop and CranioBiotic Technique (LS/CBT).***

Your LS/CBT examination is designed to identify many possible causes of inflammation, toxicity and dysfunction in your body. It will also help to identify any obvious nutritional deficiencies. Your examination will utilize Muscle Response Testing. A positive Muscle Response Test occurs when a previously strong muscle becomes weak when localized points on your body are stimulated – or when your body is exposed to a specific remedy, test vial or magnetic field. Your treatments will involve the use of magnets and gentle manual stimulation of specific areas on your body.

## The LymeStop/CBT Procedures include:

- Consultation and comprehensive LS/CBT examination
- 5 office visits to treat:
  - All identified Lyme-related infections
  - Any other infections and/or allergies
- All nutritional support for 4 months
- Your 3-month re-examination with any necessary followup treatment

**Total Fee for the above services: $3,300***

*** A $500 non-refundable deposit is due at the time your appointment is scheduled. This amount will be applied to the total cost of your care.**

- **We are unable to accept any type of insurance as payment.**
- **Payment in full is expected at time of service. We accept cash, checks, Visa and MC.**

✔ *I understand and agree to the above Office Procedures and Fees.*

Signature: _____

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# Informed Consent Agreement

***I, _____, hereby request that Dr. M. Anthony Smith evaluate and treat me (or my dependent) with LymeStop (LS) and CranioBiotic Technique (CBT), hereafter referred to as LS/CBT.***

I understand that LS/CBT techniques and procedures are not medical diagnostic procedures, and that a definitive medical diagnosis of allergens, infectious agents, toxins, parasites, and biochemical dysfunctions may require specific objective medical laboratory testing procedures, for which LS/CBT techniques are not substitutes. Instead, the purpose of the LS/CBT evaluation is to determine how your nervous system perceives those types of issues. LS/CBT treatment then attempts to optimize your immune system's recognition of those problems so that it can effectively correct them.

I understand that LS/CBT utilizes Muscle Response Testing, like many medical testing procedures, is not 100% accurate. I also understand that the LS/CBT techniques and procedures that are utilized in evaluating, investigating, examining or treating include the use of magnets, energetically-imprinted test vials, manual therapy, nutritional therapy and acupuncture-like points on the body. I also understand that the results of medical lab testing may differ from the results of LS/CBT evaluations.

I understand that the results and benefits of LS/CBT are not guaranteed, and that some people do not benefit from them. I also understand that my symptoms will improve only if the cause(s) of those symptoms are successfully identified and corrected with LS/CBT procedures.

I understand that LS/CBT is not an effective treatment for life-threatening (anaphylactic) allergies, and that I must never expose myself to life-threatening allergens. I also understand that LS/CBT is not a method of diagnosing or treating cancer, and that medical oncologists are the only doctors who are qualified to perform those procedures.

The LS/CBT treatment has been explained to me, and I understand that certain immune responses or detoxification symptoms may result from my treatment. These may include, but are not limited to: fatigue, fever, chills, nausea, headache or body aches. I understand that I am prohibited from receiving treatment with magnets if I have a heart pacemaker. I understand that if any unexpected flare-up of my symptoms should occur, I am responsible for obtaining appropriate medical care for those symptoms.

I understand that I am not being asked to discontinue any other type of care that has been prescribed by my doctor(s), unless otherwise directed by the doctor(s) who prescribed them. I also understand that any improvement in my health that results from my LS/CBT treatment may result in a change in the dosage for my medication which other doctors have prescribed for me. I agree that I will consult my medical provider to determine if my prescription needs to be changed.

Please initial after reading this page_____

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# Informed Consent Agreement

I understand that I should not discontinue any health care provided by other health care providers, and that I should fully inform other health care providers about any changes in my symptoms or conditions that result from the application of LS/CBT procedures. I understand that I may discontinue my LS/CBT treatment at any time. However, I understand that the premature termination of my care may be detrimental to any improvement I have obtained.

I understand that Dr. Smith is a chiropractic physician, and not a medical doctor or a doctor of osteopathy, and he does not practice medicine. I understand that LS/CBT techniques and procedures were developed by Dr. Smith, and that they are an experimental, alternative form of healthcare which is not yet proven by medical science, not yet subjected to chiropractic peer review nor taught in chiropractic colleges, and may not be covered by any health insurance, Medicare or Medicaid.

I have read the above statements, and I have been provided the opportunity to ask any questions regarding LS/CBT procedures. I have also been informed that I am to notify Dr. Smith if I develop any problems during my treatment. I understand the conditions stated above, and hereby consent to participate in this type of care. By signing below, I agree to the terms set forth above.

I have executed the foregoing this _____ day of _____

_____ _____

Signature Printed Name

_____ _____

If Minor, signature of parent or guardian Parent or Guardian's Printed Name

_____ _____

Witness Signature Witness Printed Name

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# Private Membership Association

LymeStop is provided by Dynamic Health, a Private Membership Healthcare Association. A Private Membership Association (PMA) is any kind of business or group where services and participation are limited to members only -- and not open to the general public. A Private Membership Association establishes its own guidelines of operation that are agreed upon by all joining members. Because of the government-run healthcare system, this change is necessary to protect our freedom of choice. Specifically, it protects our right to continue to provide holistic alternative healthcare, and your right to receive our services without restriction. Unfortunately, many progressive clinics like ours have experienced an increasing amount of government interference. However, a Private Membership Association protects our freedom of choice and association as stated in the 1st and 14th Amendments of the U.S. Constitution. You will be asked to review and sign a Membership Agreement. Membership dues are a legal requirement to join a Private Membership Association. We have chosen a fee of only $10.00 for a lifetime membership to Dynamic Health. The Association does not bill insurance for services rendered. It also does not provide reports, treatment plans or diagnostic coding for the purposes of insurance reimbursement. Our Private Membership Association gives us the constitutional right to gather in private, and practice and receive the type of health care that we choose.

# MEMBERSHIP AGREEMENT

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

1. This Association of members hereby declare that our main objective is to maintain and improve the civil rights, constitutional guarantees, and political freedom of every member and citizen of the United States of America. We believe and affirm 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.

2. 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, right to contract, 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, freedom of choice in health care, and political freedom of every member of this Association.

IT IS HEREBY DECLARED that we are exercising our right of "freedom of association" as guaranteed by the First and Fourteenth Amendments of the U.S. Constitution and equivalent provisions of the various state constitutions. This means that our Association activities are restricted to the private domain only.

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 number those members who are the most skilled to assist and facilitate the actual performance and delivery of therapy, treatment and care.

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4. We proclaim the freedom to choose and perform for ourselves the types of therapies and treatment modalities that we think best for diagnosing, 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 health care options that include, but are not limited to, cutting edge treatment modalities and therapies practiced by any type of health care practitioner -- whether traditional or nontraditional, conventional or unconventional.

5. Specifically, the mission of our Association is to provide members with what we feel are the most effective, natural alternative treatments available – at an affordable fee. We emphasize the evaluation and treatment of members' overall health, and not merely their symptoms. The Association provides consultations, examinations, treatment, and advice for a wide variety of health-related problems. The Association's examinations utilize muscle response testing, energetically-imprinted vials, magnets, and specific points on the body. The Association's treatments are designed to correct health problems that are related to: pathological microorganisms (viruses, bacteria, fungus, parasites and protozoa); food and environmental allergies and/or sensitivities; environmental toxins; dysfunction of the organs, glands, soft tissues and joints; and nutritional deficiencies. The Association's treatments utilize, but are not limited to: magnets, therapeutic touch, energetically-imprinted vials, specific manual therapy and nutritional therapy. The association also offers nutritional products and health-related information to its members.

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

**MEMORANDUM OF UNDERSTANDING**

I understand that the fellow members of the Association who provide services and care, do so in the capacity of a fellow member and not in the capacity as a licensed health care provider. I further understand no doctor-patient relationship exists within the association, but only a contract member-member Association relationship. In addition, I have freely chosen to change my legal status as a public patient, customer or client 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. It is also my responsibility to educate myself as to the efficacy, risks, and desirability of same. I understand that the acceptance of the offered or recommended diagnosis, therapy, treatment and care is my own carefully considered decision. Any request by me to a fellow member to assist me or provide me with the aforementioned diagnosis, therapy, treatment and care is my own free decision and it is also an exercise of my rights, and made by me for my benefit. 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. This excludes any 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 M. Anthony Smith as the person best qualified to perform services to members of the Association, and have entrusted him to select other members to assist him in carrying out that service.

In addition, I understand that the Association is protected by the First and Fourteenth Amendments to the U.S. Constitution. It is therefore outside the jurisdiction and authority of Federal and State Agencies and Authorities concerning any and all complaints or grievances against the Association, or any Association Trustee(s), members or other staff persons. All rights of complaints or grievances will be settled by an

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Association Committee and will be waived by the member for the benefit of the Association and its members. Because the privacy and security of 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. Any medical or 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.

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

I understand that any 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 health 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 the Association are not covered by any health insurance or 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 forgo 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. I refuse to share them with any State Licensing Board, the FDA, FTC, 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 and approve products. 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 for benefits that I receive that are declared by the Trustee to be "special assessments", per the Association's current fee schedule.

I enclose the sum of Ten Dollars ($10.00) as consideration for my one-time lifetime membership, said term beginning with the date of the signing of this contract. I hereby certify, attest and warrant that I have carefully read the above Contractual Application for Membership and I fully understand and agree with same.

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

_____

Member's Name (please print legibly) (or name of legal guardian if applicant is under 18 )

_____

Member's Signature (or signature of legal guardian)

Member's contact information:

_____

Street City State Zip

_____ _____

best contact phone# email address

DYNAMIC HEALTH

By_____

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