

ARP Health Systems
Harmonic Energy Balancing (HEB)
Renewal Application

Please check the applicable information if you are **renewing** for another year:

- I am enrolling only myself (\$125)
- I am enrolling myself and one other family member (\$250)
- I am enrolling myself and two other family members (\$375)
- I am enrolling my entire family: 4 members or more (\$500)
- I am enrolling my home (\$125)
- I am enrolling my business (\$125)
- I am enrolling my pet(s): (\$50 per pet) Number of pets:

Total Amount: \$

Please print:

Name: Date: Gender:

Street Address: City:

State: Zip: Email:

Home phone: () - Cell phone: () -

Date of birth: / / City Born In: State:
Month Day Year

Type of payment:

Check Credit Card (Visa or Mastercard only):

CC Number: - - -

Expiration Date: / 3 Numbers on back:

Billing Address if different than above:

Street Address: City:

State: Zip:

I authorize ARP Health Systems to charge my credit card for 12 monthly payments.
(Total amount divided by 12 plus \$5 monthly fee for processing)

(Please be sure to sign application – next page...)

Family Members I am enrolling in the HEB Program:

Note: ARP Health Systems must have a signature below for each family member over 18 years of age) A picture is needed for each enrollee. (ARP will contact you with specific picture instructions.) If enrolling your home or business, ARP Health Systems will contact you for information needed.

1. Name: _____ DOB: ___/___/___

Birth City & St: _____ Signature: _____

2. Name: _____ DOB: ___/___/___

Birth City & St: _____ Signature: _____

3. Name: _____ DOB: ___/___/___

Birth City & St: _____ Signature: _____

4. Name: _____ DOB: ___/___/___

Birth City & St: _____ Signature: _____

5. Name: _____ DOB: ___/___/___

Birth City & St: _____ Signature: _____

6. Name: _____ DOB: ___/___/___

Birth City & St: _____ Signature: _____

Please read carefully:

I (we) understand that the HEB (Harmonic Energy Balancing) will not diagnose, prescribe, cure, or treat. I (we) understand that the HEB does not replace medical care by a licensed medical physician.

Signature of Applicant: _____ **Date:** _____

Mail or E-mail Application to:

ARP Health Systems
83 E. US Hwy 54
Camdenton, MO 65020
E-mail: ARPHealthSystems@gmail.com