ARP Health Systems

Harmonic Energy Balancing (HEB)

New Application

Please check the applicable information if you are a **new** applicant:

___ I am enrolling only myself ($250)
___ I am enrolling myself and one other family member ($500)
___ I am enrolling myself and two other family members ($750)
___ I am enrolling my entire family: 4 or more members ($1000)
___ I am enrolling my home ($125)
___ I am enrolling my business ($125)
___ I am enrolling my pet(s): $50 per pet. No. 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 fill out reverse side)

Family Members I am enrolling in the HEB Program:

<u>Note</u>: 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