Eckardt Johanning, M.D., M.Sc., P.C.
Occupational and Environmental Life Science

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Fungal Research Group Foundation, Inc.
www.fungalresearchgroup.com
www.bioaerosol.org
www.wholebodyvibration.org

Offices: Albany, New York City
& Frankfurt/Main, FRG

Patient Information & Consent

Date: __/__/____

Name: (first)______________ (last) ______________ DOB: __ / __ / __
SS#: ___ - __ -___

Address: _______________City:_____________ State: __ Zip: ______

Telephone No: ___- ___ ____ (home) ___ - ___ ____ (work)
Cellular Phone#: ___ - ___ ____ Fax#: ___ - ___ ____

Employer:_______________________________________

Insurance Carrier: ____________Insured's Name: ____________________

Policy/Group#:_______________ Insured's Date of Birth: __ / __ / __

Relationship to Insured: Self __ Spouse _ Child __ Other __

Is condition related to employment?: yes _ no _ If yes, please provide the Worker's Compensation#:____________ Date of Accident/Injury:________

Consent

I herewith consent to the medical evaluation and treatment by Dr. Eckardt Johanning or his associates. I consent that anonymous health data or lab results may be used for medical research and education. I hereby assign *to* Dr. Eckardt Johanning, where applicable all payment for medical services, even if he does not accept assignment from my medical insurance company but not to exceed stated charges.

I hereby acknowledge that Dr. Johanning is not under any obligation to provide any legal testimony or testimony that is favorable to me or has not provided me with any assurances of a "positive" evaluation and/ or testimony to support any legal claims. A photographic copy of this authorization shall be as valid as the original. I have also received a copy of the Notice of Privacy Practices.

Your Signature:

Name__________________ _____________ ____ ___/___/ ____
City State Date

(Rev. 11/12)

"is a member of" ISIAQ ACOEM American College of Occupational and Environmental Medicine