WorldPath Health, Inc.
300 Mount Auburn Street SUITE 511
Cambridge MA 02138
617-450-0011

PERSONAL AND CONFIDENTIAL
Fax Information to WorldPath Health Inc. 617 450-0051

DEMOGRAPHIC INFORMATION

FIRST NAME:____

LAST NAME:____

DATE OF BIRTH (MM/DD/YYYY): ________/______/____________

HOME STREET:____

HOME CITY:____

HOME COUNTRY: ____

TELEPHONE: ____________________________ MOBILE PHONE:_________________________________

EMAIL ADDRESS: ____

ADDRESS IN UNITED STATES

STREET_______________________CITY__________________STATE__________ ZIP CODE_____________

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME: ____

TELEPHONE: _________________________ MOBILE PHONE:______________________

REASON FOR VISIT: ____

REV 150316

WorldPath Health, Inc.
300 Mount Auburn Street SUITE 511
Cambridge MA 02138
617-450-0011

PERSONAL AND CONFIDENTIAL
Please Fax Information to WorldPath Health Inc. 617 450-0051

PATIENT NAME:____

DEPOSIT: USD$ 5000.00 COST ESTIMATE: USD$ To Be Determined

Please note: This deposit is required in order to complete your registration with WorldPath Health, Inc., initiate the initial review of medical records that has been requested, and to coordinate your detailed evaluation and treatment plan. Following the review, you will receive a cost estimate for recommended services coordinated by WorldPath Health, Inc.

Should you decide to proceed, any unused portion of your deposit will be applied to future charges. WorldPath Health, Inc. requires full payment of your estimated charge in advance of authorization for travel and treatment.

Please note that any cost estimate reflects may change during the course of your treatment. If additional services are provided, you will be responsible for the additional costs. A refund will be provided for the remaining balance after all charges have been accounted. If you decide not to proceed, any unused portion of your initial deposit will be promptly returned to you.

For all international patients seeking health care in the United States of America, WorldPath Health, Inc. requires full payment for all estimated services two weeks in advance of travel. We must have a credit card authorization or wire transfer of funds before we can confirm appointments and authorize travel to the United States. Also, we must have authorization to bill your credit card for any additional charges that might accrue during the course of your treatment. We will provide you with invoices of all charges

I have read and agree with the above statement.

SIGNED: ____________________________ DATE:________________

WorldPath Health, Inc.
300 Mount Auburn Street SUITE 511
Cambridge MA 02138
617-450-0011

PERSONAL AND CONFIDENTIAL
Please Fax Information to WorldPath Health Inc. 617 450-0051

PAYMENT INFORMATION

I authorize the initial charges to my card noted below. Also, I confirm that my signature below indicates I agree that any additional charges, beyond those estimated, that I have requested or have been deemed medically necessary are proper to charge to this credit card.

CREDIT CARD: TYPE: VISA MASTERCARD AMERICAN EXPRESS

CREDIT CARD NUMBER:________________________________ EXPIRATION DATE: ________________

SECURITY CODE: ________________ CARDHOLDER NAME: ___________________________________

ADDRESS OF CARDHOLDER: ____

____

WIRE TRANSFER:

CALL WORLDPATH HEALTH, INC. AT 617-450-0011 FOR BANKING INFORMATION

Please inform the Bank of your incoming wire and you will be promptly notified upon receipt of funds. Please include your name on the wire so that we may properly credit your account