SuperSmartFoods

brought to you by directionH™
(A Private Membership Association)
MEMBERSHIP CONTRACT

Membership
□ $10 with Thank You Program Benefits – Social Security Number Required
□ $10 without Thank you Program Benefits – No Social Security Number Required

I, _____,

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

1. This Association of members hereby declares 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 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. As members, we affirm our belief 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. 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, 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, freedom of choice in food, freedom of choice in financial matters, freedom of choice in education, and political freedom of every member and citizen of the United States of America.

IT IS HEREBY Declared that we are exercising our right of "freedom of association" as guaranteed by the 1st and 14th 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 products and management of care.

4. We proclaim the freedom to choose and perform for ourselves the types of products and managed care modalities that we think best for the analysis, management, and prevention of the many dysfunctions of our minds and bodies and for achieving and maintaining optimum wellness. We proclaim and reserve the right to include health options that include but are not limited to cutting edge management modalities and therapies practiced or used by any types of healers or therapists or practitioners the world over whether traditional or nontraditional, conventional or unconventional.

5. More specifically, the mission of our Association is to provide members with the highest level of quality products, care, and education. Our Association understands that wellness includes but is not just limited to body, mind, and soul, but also includes opportunities of financial health. The Association provides comprehensive, conventional, complementary alternative care and the most advanced technologies to analyze all aspects of a member's dysfunction and provide the most effective means of management at an affordable fee. More specifically, the Association specializes in Health Products, Health Education, Health Modalities, and offers Local Chapter Distributions as benefits to members.

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

MEMORANDUM OF UNDERSTANDING

I understand that the fellow members of the Association that 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 that within the association no doctor-patient relationship exists 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 and to educate myself as to the efficacy, risks, and desirability of same and 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 in an exercise of my rights and made by me for my benefit, and 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, except for 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 Trustees and members have chosen Dr. Thomas Wilson and Pamala Wilson as the persons best qualified to perform services to members of the Association and entrust them to select other members to assist them in carrying out that service.

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

I understand that the 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 medical 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 will not be covered by my health insurance and not at all by 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 that I refuse to share with the State Medical 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 or financial guarantee. 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 as levied those benefits that I receive that are declared by the Trustees to be "special assessments", per Fee Schedule.

I enclose the sum of $_____ as consideration for my one-time lifetime membership contract, said term beginning with the date of the signing of this contract, and by these presents do hereby certify, attest and warrant that I have carefully read the above and foregoing DirectionH™'s Contractual Application for Membership and I fully understand and agree with same.

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

_____ _____

Member's Name (Please Print Legibly) Member's Signature
name of legal guardian if applicant under 18 years **signature of legal guardian if applicant under 18 years**

Members Address and Phone #:

_____

Street City State Zip Code

_____ _____

Home/Work/Cell #s Email Address (please print clearly)

Office Use Only
Approved and accepted

Date_____

By_____

Method of Payment:
□ **Cash** □ **Check** □ **Credit Card**