INFORMED CONSENT

ADVANCED HEALTH CLINIC, LLC; SHEPARD CREEK CLINIC, LLC; INFUSED HEALTH & NUTRITION, LLC; HEALTH & NUTRITION, LLC; THERAPEUTIC SPA, LLC; AHC II, INC.; MARTHA L. BRAY, FNP-BC, APRN, AHN-BC, BCIM; and each of their CONTRACTORS, NURSE PRACTITIONERS, NURSES, ASSISTANTS, EMPLOYEES, AGENTS, and STAFF

THIS INFORMED CONSENT CONSTITUTES A LEGALLY BINDING AGREEMENT. PLEASE READ IT CAREFULLY AND MAKE SURE YOUR QUESTIONS ARE SATISFACTORILY ANSWERED BEFORE INITIALING EACH SECTION AND SIGNING BELOW INDICATING YOUR ACCEPTANCE, AGREEMENT, AND CONSENT TO BE TREATED

Advanced Health Clinic, LLC, Shepard Creek Clinic, LLC, Infused Health & Nutrition, LLC, Health & Nutrition, LLC, Therapeutic Spa, LLC, AHC II, Inc., and Martha L. Bray, FNP-BC, APRN, AHN-BC, BCIM, an individual, together with each of their members, managers, owners, shareholders, directors, nurse practitioners, registered nurses, nursing assistants, contractors, agents, employees, and staff (individually and collectively the "**Providers**") have agreed to make available various services, treatments, therapies, procedures, machinery, equipment, and devices including, without limitation those shown or described at https://advancedhealthclinic.com and those described below (individually and collectively, the "**Treatments**"), together with various health or nutrition related products described, including, without limitation, holistic and natural items, vitamins, minerals, herbs, homeopathy, nutrients, whole foods, diodes, books, (individually and collectively, the "**Product(s)**"), at the clinic and facilities located at 630 W. Shepard Lane, Farmington, Utah 84025 (collectively, the "**Clinic**").

GENERAL UNDERSTANDING:

_____ **(Please Initial)** I understand that Martha L. Bray,

- (i) is a Family Nurse Practitioner, Board Certified, Advanced Practice Registered Nurse (FNP-BC, APRN, Certified Holistic Nurse (AHN-BC), Board Certified Integrative Medicine Practitioner (BCIM), Certified Bionetic Practitioner, and Certified Life Coach.
- (ii) is an employee of AHC II, Inc., an Independent Contractor of Advanced Health Clinic, LLC.
- (iii) is licensed by the State of Utah to practice independently as a Family Nurse Practitioner.
- (iv) specializes and employs methods that may be considered "unconventional" and/or "unorthodox," also known as "alternative," "integrative," "holistic," and/or "complimentary" medicine.
- (v) as a Family Nurse Practitioner, is a mid-level provider.
- (vi) recommends that I consult and work with my physician and/or a specialist if I have any serious illness and/or disease, and that I, or my representative(s), are responsible for my health care decisions.
- (vii) may utilize a BioCommunication device(s) to empower me through wellness coaching so I may make informed decisions about my life, health, and wellness choices.

_____ **(Please Initial) GENERAL DESCRIPTION OF TREATMENTS**. I understand that the terms "**Treat**," "**Treating**," or "**Treatment(s)**," include, without limitation, medical, diagnostic, therapeutic, and nutritional treatments, procedures, medications, supplements, essential oils, NAET allergy reduction, Bioidentical Hormone Replacement Therapy, Stem Cell Treatments, laser therapy, Pulse Electromagnetic Field Therapy (PEMF), detoxification programs, weight loss plans, nutritional plans, therapeutic spa therapies, Intravenous Micronutrient Therapy, including insertion of needles into my skin and veins, the injection of standardized formulas which may include various nutritional substances, homeopathic medicines, and FDA approved prescriptive medicines, local anesthetic (Procaine or Lidocaine), concentrated sugar water or dextrose, ozone (03), and local subcutaneous anesthetic infiltration, including homeopathics, vitamins, minerals, amino acids, herbs, allergy serums, injections (e.g., intravenous, subcutaneous, intramuscular), Prolotherapy and/or Prolozone Therapy, Ozone (03) Therapy, which may include ear, nasal, sinus ozone therapy, Ozone Major AutoHemotherapy (MAH), Minor AutoHemotherapy (mAH), and/or BioPhotonic Therapy (BPT) often referred to as Ultraviolet Blood Irradiation Therapy (UBI Therapy). I am informed and understand that MAH, mAH, methods involve removing a small volume of my own blood (average = 1.5cc/pound body weight to a maximum of 250cc's) under sterile conditions, briefly exposing that blood to ozone (03) and re-infusing the blood back into my body intravenously, subcutaneously, or intramuscularly. The blood is also treated with a very small amount of temporary acting anti-coagulant (heparin). I am informed that BPT involves removing a small volume of my own blood (average = 1.5cc/pound body weight to a maximum of 250cc's) under sterile conditions, briefly exposing that blood to selected frequencies of Ultraviolet Light and/or ozone (03) and re-infusing the blood back into the body. The blood is also treated with a very small amount of temporary acting anti-coagulant (heparin).

_____ **(Please Initial) GENERAL DESCRIPTION OF PRODUCTS**. I understand that, in addition to Treatments I select, I will have the option, at my sole discretion and choosing, to select and purchase the Products.

_____ **(Please Initial) ACCEPTANCE OF TREATEMENT RISKS, SIDE EFFECTS, AND COMPLICATIONS**. I am fully informed and understand that many or all the Treatments and/or Products are considered "unconventional," "unorthodox," "alternative," "integrative," "holistic," and/or "complimentary" medicine. Accordingly, being so informed, I fully and completely accept the risk that the diagnoses and Treatments provided to me, and/or my children, as well as Products I or my children may use or consume, may result in injury, disability, death, side effects, and/or complications, including, without limitation, infections, swelling,

increased pain, bleeding, scarring, scar or wound enlargement, keloid formation, asymmetry, temporary or permanent alteration in sensation, allergic reaction, discoloration, the need for additional surgery, soreness, itching, infection, injury to nerves, internal or external leaking of fluid, scarring at injection sites (all of which, except the leaking of fluid, may be permanent), lumpiness or permanent skin contour irregularities at the site of Treatments, spinal cord injuries, pneumothorax (air on the outside of the lung), paralysis, dizziness, numbness, no benefit from Treatments and/or Products, or other serious or debilitating injuries or death. I am informed and understand that the side effects of BPT therapy include minor bruising at the injection site, potential minor bleeding from the heparin, mild temporary "healing reactions" (low grade fever, minor muscle aches or joint aches, possible prescription drug - BPT interaction (i.e., sulfa drugs, tetracyclines, phenothiazines) and the rare possibility of photoallergy in the case of allergy to sunlight.

_____ **(Please Initial) EXPERIMENTAL NATURE OF TREATMENT AND/OR PRODUCTS**. I understand that the evaluation, diagnosis, Treatments and Products may consist, in whole or part, of experimental procedures, techniques, methods, and/or substances for which no governmental (including the U.S. Food and Drug Administration (“FDA”)), scientific or medical authority has issued any guidelines or statements as to the safety, outcome, or efficacy thereof. I further acknowledge that the safety record of the Treatments and/or Products is based only on empirical and anecdotal evidence, which only shows that the Treatments and Products appear to be relatively safe.

_____ **(Please Initial) TREATMENTS MAY BE INEFFECTIVE**. I understand, and I willingly and knowingly accept the risk, that the Treatments and/or Products MAY or MAY NOT improve, alter, address, or decrease my pain, symptoms, condition, or complaints.

_____ **(Please Initial) EXPLANATION OF TREATMENTS AND PRODUCTS, QUESTIONS ANSWERED, AND RESPONSIBILITY**. I understand that in the absence of an emergency or extraordinary circumstances no Treatment or Product will proceed, be given, or administered to me or my children unless and until the nature, details, sequence and/or timing of such Treatment and/or Product has been explained to me and I have had the opportunity to discuss the Treatment and/or Product and have all my questions answered to my satisfaction prior to giving my consent or consuming the Product. I accept full responsibility to make certain that I (a) understand the Treatment and/or Product to the extent that I desire, (b) have had all my questions answered regarding the Treatment and/or Product and their attendant risks, (c) am satisfied with the explanations I have received, and (d) willingly and knowingly accept all risks associated with the Treatment and/or Product. I understand that no explanation or description of the Treatments and/or Products can ever fully explain or address every possible risk, side effect, or complication that may or could arise from the Treatments and/or Products; nevertheless, by signing this Informed Consent, I acknowledge my willingness to assume, and my acceptance of, all such risks; and I acknowledge that my consent to Treatment, and/or my or my children’s consumption of the Products, is informed, willing, and voluntary.

_____ **(Please Initial) PERSONS ADMINISTERING TREATMENTS**. I understand that my, or my children’s, Treatments, and/or our consumption of the Products, may be administered by Martha L. Bray, or any of the other Providers, as defined herein, including, without limitation, nurse practitioners, registered nurses, nursing assistants, consultants, or staff members. I am aware that among those who assist and help me and/or my children may be medical, nursing, and/or other health care personnel and/or trained staff who may be in training, who unless requested otherwise, may participate in patient care as part of their education. I further consent to the presence of service representatives and/or technicians from manufacturers of equipment or devices to assist in performing and/or operation of such equipment and/or devices during Treatments.

_____ **(Please Initial) CONSENT FOR TREATMENT; IMPLICATIONS OF MY CONSENT**. I give my consent to, and authorize, the Providers, or any of them, to provide me, and/or my children, with the Treatments and/or Products that I select. I understand that my consent to any Treatment denotes that I have (a) discussed it, (b) had all my questions satisfactorily answered, (c) understand the attendant risks, and (d) willingly and knowingly accepted all risks associated with the Treatment and/or Product. I understand that I have the right to refuse any proposed Treatment or Product offered. I agree that in the event of an adverse reaction following any Treatment, or following the consumption of any Product, I will contact Advanced Health Clinic, LLC for further instructions; or, if it is a medical emergency, I will call 911.

_____ **(Please Initial) BIOCOMMUNICATION DEVICE IS NOT A MEDICAL DIAGNOSIS TOOL.** I am informed and understand that a BioCommunication device is NOT designed to diagnose, recommend, prescribe, treat, prevent, or cure any disease, illness, condition, or symptom, nor is it, or will it, be used by any of the Providers for any of those purposes. I further understand that the use of a BioCommunication device by the Providers is solely at my request with full knowledge of, and notwithstanding the foregoing disclosure.

_____ **(Please Initial) MY DUTY TO PROVIDE COMPLETE AND ACCURATE INFORMATION**. I agree to provide complete and accurate information concerning:

(i) all prescription and non-prescription medications and dietary supplements I, and/or my children, are currently taking, and to provide updates should this list change.
(ii) all known allergies with a description of all allergic or adverse reactions that I and/or my children have had to any medicines, dietary supplements, or medical treatments of any kind.
(iii) my or my children's current medical status before any Treatment is performed or Product consumed.

I certify that all information I provide to the Providers, including, without limitation, the information required by this Informed Consent, is, and will be, true, accurate, complete, and up to date to the best of my knowledge.

_____ **(Please Initial) I AM DIRECTING MY AND/OR MY CHILDREN'S TREATMENTS**. I further understand, acknowledge, and agree that selection of all Treatments received and/or Products consumed are patient and/or client directed, and that I oversee, and direct the Providers to perform the Treatments I may select, or provide and/or administer the Products consumed, of my own volition.

_____ **(Please Initial) SCIENTIFIC RESEARCH:** I understand that I will not be subjected to any research or experimental procedure without my full knowledge and consent. Nevertheless, I consent to the use of my clinical results and lab reports for research and scientific purposes, to aid in the advancements of medical knowledge, provided my identity is kept confidential.

_____ **(Please Initial) NO INSURANCE BILLED:** I understand that no Provider belongs to a Preferred Provider Program (PPO) or a Health Maintenance Organization (HMO). Nor are any of them Medicare or Medicaid providers. Consequently, insurance is not accepted for any services, products, or Treatments. The Providers are fee-for-service providers. Accordingly, I understand that I am, and will be, responsible for paying all charges that I or my children incur. The services, Treatments, and Products provided by the Providers are not coded for, nor are they billed or sent to, insurance companies. I acknowledge that the Providers will not provide any information to, nor correspond with, my Insurance Company.

_____ **(Please Initial) SEVERABILITY:** If any term, provision or condition of this Informed Consent, or any application thereof, should be held by a court of competent jurisdiction to be invalid, void, or unenforceable, all remaining terms and conditions of this Informed Consent shall continue in full force and effect, shall in no way be affected, impaired, or invalidated thereby, and shall be enforced to the greatest extent permissible under the law.

_____ **(Please Initial) PRIVACY POLICY AND CONFIDENTIALITY:** I am informed and understand that my health information is private and protected by law. My information will only be used or disclosed for the purpose of giving care, billing, or supporting day to day operations. I have the right to review my file upon providing a written request. I may restrict all or part of my health information from being released. I understand that, if I request information to be transmitted electronically, my private information may not be protected. The Providers transmit from a secure, encrypted network server; however, they cannot guarantee that any information I receive will be received through a secure network on my end. The Providers will take reasonable steps necessary to protect my privacy. A more detailed version of the Providers' privacy policies is available online or at the Clinic. If I contact the Providers by electronic means, (i.e., website, Facebook, social media, text, email, etc.), I understand that this is not a secured form of communication, and my private health information may not be protected. I understand that by contacting the Providers via those means, I am waiving my Privacy Rights. I understand and accept that my information may be unprotected during electronic communication.

_____ **(Please Initial) HIPAA NOTICE OF CLIENT PRIVACY PRACTICES**. I have received a HIPAA NOTICE OF CLIENT PRIVACY PRACTICES. I have had a chance to ask questions about privacy policies, and I give my permission to the Providers to disclose my name and/or protected health information in accordance with such policies. In addition, I authorize the Providers to discuss my health care information with other health care providers I may see at the Clinic to facilitate the best coordination of my care. I consent to having my picture taken and placed in my file for identification purposes. I further understand that my chart will always remain the property of Advanced Health Clinic, LLC.

____ **(Please Initial) CONFLICT RESOLUTION; BINDING ARBITRATION; WAIVER OF RIGHT TO JURY TRIAL:** I agree to attempt resolution of any claim, dispute, or disagreement I have with the Providers, or any of them, in person, for a period of sixty (60) days following my written notice to Advanced Health Clinic, LLC. If this is unsuccessful, then I agree to enter good faith non-binding mediation in Farmington, Utah using a retired judge as mediator within forty-five 45 days. If unable to settle through mediation within that period, I agree that any claim or dispute arising out of this Informed Consent shall be subject to the Alternative Dispute Resolution Procedure ("ADR") set forth in Exhibit A, attached hereto and incorporated herein by this reference. I waive all right to trial by jury of any claim or cause of action based upon or arising out of this Informed Consent or any service, Treatment, or Product I or my children receive at the Clinic, including contract claims, tort claims, breach of duty claims, strict liability claims, and all other common law or statutory claims. I have reviewed this waiver and knowingly and voluntarily waive my jury trial rights, having

had the opportunity to first consult with legal counsel of my choice.

_____ **(Please Initial) NO MEDICAL LIABILITY INSURANCE:** I am informed and, by signing below, I acknowledge my awareness that the Providers may not be insured, covered, or protected by medical liability insurance. Furthermore, I am aware that most Treatments that are offered are not covered by medical liability insurance.

_____ **(Please Initial) DISCLAIMER OF WARRANTIES: I understand that the Providers make no representations, claims, guarantees, promises, or warranties of any kind whatsoever, express or implied, regarding the safety, efficacy, benefits, ability to cure, or outcome of the Treatments or Products, or any of them; and they expressly disclaim all warranties, express and implied, concerning the Treatments and Products, including, without limitation, any implied warranties of merchantability and fitness for a particular purpose.**

_____ **(Please Initial) ASSUMPTION OF RISK AND RELEASE: I acknowledge that all Treatments and Products received and/or consumed by me, and/or my children, are client directed and may involve serious health risks, including injury, side effects, disability, or death. In consideration of my and/or my children's receipt of Treatments and/or Products offered by the Providers, and our use of the Clinic, and as an inducement for the Providers to make available the Treatments, Products, and use of the Clinic, I agree, on my behalf, and on behalf of my minor children, to assume and accept all risks associated with the Treatments and Products we receive, as well as the risks associated with our presence at and use of the Clinic facilities, including those risks caused by the negligence of any of the Providers. I release, indemnify, and forever hold the Providers harmless from and against any and all claims, demands, liabilities, actions, or causes of action for injury or damage of every kind and nature arising incident to or in connection with the Treatments made available by Providers, the Products I and/or my children use or consume, as well as our presence at and use of the Clinic, and from any other cause including the negligence of the Providers. I agree never to sue the Providers on any claim occurring or arising out of the Treatments received from the Providers, the Products used or consumed by me and/or my children, or my or my children's presence at, and/or use of, the Clinic. All the foregoing protections shall be available to others who may be assisting at the Clinic or with the Treatments of Providers. This Informed Consent is binding on my heirs and assigns.**

_____ **(Please Initial) PAYMENT POLICY:** I understand that payment is due at time of service and that all charges for Treatments and Products are payable immediately to Advanced Health Clinic, LLC, by cash, check, or major credit card. In the event of a returned check, I agree to reimburse Advanced Health Clinic, LLC the total amount of the check by cash or credit card with an additional $75 returned check service fee. I agree to pay 2% interest per month on all amounts thirty (30) days or more past due. I also agree to pay all collection costs, including attorneys' fees, expenses and costs incurred in the event it becomes necessary for Providers to pursue collection of past due amounts.

_____ **(Please Initial) GOVERNING LAW**: I agree that this Informed Consent shall be interpreted in accordance with the laws of the State of Utah, and I consent and agree to the exclusive jurisdiction and venue of the Second Judicial District Court of Davis County, State of Utah, in the event any action is brought to enforce any provision hereof or which arises out of the same.

_____ **(Please Initial) RIGHT TO HAVE ATTORNEY REVIEW**. We understand that you may feel uncomfortable signing this form. If that is the case, please do NOT sign until you discuss it with an attorney. Although the Providers will not be able to provide any professional services to clients and or patients who choose not to sign, Providers will provide any medical records in their possession to you at your request.

BY SIGNING THIS INFORMED CONSENT, I ACKNOWLEDGE THAT I AM OF SOUND MIND, HAVE READ AND UNDERSTAND IT (OR I HAVE DISCUSSED IT WITH MY ATTORNEY), AND I WILLINGLY AND KNOWINGLY ACCEPT AND AGREE TO ABIDE BY ALL TERMS, UNDERSTANDINGS, AND CONDITIONS DESCRIBED HEREIN

CLIENT NAME (PRINT): ____

SIGNATURE: ______________________________ **Date** ____________________

PARENT OR GUARDIAN SIGNATURE IF UNDER 18: ______________________________

Address: ____

City ______________________________ **State** __________ **Zip Code** ______________

EXHIBIT A
Alternative Dispute Resolution Procedure

1. **Substantive Law and Arbitrability**. The law of Utah shall apply to this Exhibit A and to any proceeding pursuant to Exhibit A. The parties' agreement to arbitrate does not constitute an agreement to arbitrate claims that would be barred by the relevant statute of limitations if such claims were brought in a court of competent jurisdiction. Any Party may assert the limitations period as a bar to the arbitration by applying to any court of competent jurisdiction, and Parties expressly agree that any issues relating to the application of a statute of limitations or other time bar can be referred to such court. A party's failure to assert a statute of limitations in court does not, however, prevent the party from raising the statute of limitations in an ADR proceeding pursuant to Exhibit A.

2. **Initiation**. To begin an ADR proceeding, a party must provide written notice to the other party of the issues to be resolved by ADR. Within 14 days after its receipt of such notice, the other party may, by written notice to the party initiating the ADR, add issues to be resolved within the same proceeding.

3. **Selection of Arbitrator**. All arbitration proceedings shall be conducted by a single arbitrator. Within 21 days following receipt of the original ADR notice, the parties will select a mutually acceptable arbitrator (preferably a retired judge) to preside in the resolution of any disputes in this ADR proceeding. If the parties are unable to agree on the selection of a single arbitrator in this 21-day period, the mediator having previously mediated the dispute shall designate an arbitrator, who will serve as the sole arbitrator for the ADR proceeding. The arbitrator shall be unbiased, impartial, free from conflicts, and have no financial interest in either party or any of their affiliates.

4. **Hearing**. No earlier than 45 days and no later than 90 days after selection, the arbitrator will hold a hearing to resolve each of the issues identified by the parties. The ADR proceeding will take place at Farmington, Utah, unless the parties agree to a different location. Except as expressly set forth in section 5, no discovery of any kind may be required or permitted relating to an ADR proceeding under this Exhibit; this includes any depositions, subpoenas, interrogatories, requests for admission, requests for production of documents or tangible items, and requests for physical inspection.

5. **Pre-Hearing Disclosures and Submissions**. At least 21 days prior to the hearing, each party will submit the following to the other party and the arbitrator:

(a) A copy of all exhibits on which such party intends to rely in any oral or written presentation to the arbitrator.

(b) A list of any witnesses such party intends to call at the hearing, and a short summary of the anticipated testimony of each witness.

(c) A list of rebuttal exhibits, and witness names (including short summaries of testimony) may be submitted to the other party and the arbitrator at least 7 days prior to the hearing.

(d) A proposed ruling on each issue to be resolved, together with a request for a specific damage award or other remedy for each issue. The proposed rulings and remedies must not contain any recitation of the facts or any legal arguments and must not exceed one page per issue.

(e) A brief in support of each party's proposed rulings and remedies, which must not exceed 30 pages regardless of the number of issues raised.

6. **Hearing Procedures**. The hearing will be conducted on consecutive days and will be governed by the following rules:

(a) Each party will be entitled to ten hours of hearing time to present its case. The arbitrator will determine whether each party has had the ten hours to which it is entitled.

(b) Each party may make an opening statement, present regular and rebuttal testimony, documents, or other evidence, cross-examine witnesses, and make a closing argument. Cross-examination of witnesses will occur immediately after their direct testimony, and cross-examination time will be charged against the cross-examining party.

(c) The party initiating the ADR will begin the hearing and, if it chooses to make an opening statement, will address not only issues it raised but also any issues raised by the responding party. The responding party, if it chooses to make an opening statement, will also address all issues raised in the ADR. Thereafter, the presentation of regular and rebuttal testimony and documents, other evidence, and closing arguments will proceed in the same sequence.

(d) Unless testifying, all witnesses (save one corporate representative) will be excluded from the hearing until closing arguments.

(e) Settlement negotiations, including any statements made therein, will not be admissible under any circumstances. Affidavits, deposition transcripts, or depositions prepared for the purposes of the ADR hearing also will not be admissible. As to all other matters, the arbitrator will have sole discretion regarding the admissibility of any evidence.

7. **Post-Hearing Brief**. Within ten days following completion of the hearing, each party may submit to the other party and the arbitrator a post-hearing brief in support of its proposed rulings and remedies. The post-hearing brief must not contain or discuss any new evidence and must not exceed 15 pages regardless of the number of issues raised.

8. **Ruling**. The arbitrator will rule on each disputed issue within 21 days following completion of the hearing. Neither Party shall be liable to the other Party for any punitive damages, indirect, incidental, special, or consequential damages of any kind, any performance of, or failure to perform, the Informed Consent, this Agreement, or any conduct in furtherance of the provisions or objectives of the Informed Consent or this Agreement, on any theory of liability, whether in an action for contract, strict liability or tort (including negligence) or

otherwise, whether or not a party has been advised of the possibility of such damages. The arbitrator shall issue a proposed ruling and remedy in favor of one of the parties on each disputed issue and may adopt one party's proposed rulings and remedies on some issues and the other party's proposed rulings and remedies on other issues. The decision of the arbitrator shall be conclusive, final, and binding upon the parties. Judgment upon the arbitral award may be entered in any court having jurisdiction over the parties or their assets. The arbitrator shall have the authority to award equitable relief if the circumstances merit. The arbitrator may, at the request of a party, issue a written opinion or otherwise explain the basis of the ruling.

9. **Fees**. The arbitrator will be paid a reasonable fee plus expenses, to be split by the parties. Each party shall be responsible for its own attorney's fees, expenses, and costs.

10. **Confidentiality.** Except as required by law, the existence of the dispute, any settlement negotiations, the ADR hearing, any submissions (including exhibits, testimony, proposed rulings, and briefs), and the rulings in any procedure initiated under this Exhibit A shall be deemed Confidential Information. The arbitrator shall have the authority to impose sanctions for unauthorized disclosure of Confidential Information.

11. **Language**. All ADR hearings shall be conducted in the English language.