Where there is an open mind and a willing heart, there is a path to healing

Dear Client,

Welcome to *Advanced Health Clinic*. We are committed to bringing you the best practitioners and services available in Integrative & Holistic Medicine and the healing arts. As you embark on this new journey (or perhaps a well-traveled path), we are excited for the new discoveries you will make about yourself, your health and your well-being as you begin to create an *advanced* lifestyle – one that is full of healing, energy, and possibility!

To assist us in making your first visit an exceptional experience, we ask that you be prepared with the following:

1. **NEW CLIENT PAPERWORK:** Please fill out all paperwork *prior* to your appointment. We prefer you mail it to us if there is time. If for any reason you do not complete your paperwork, your appointment may be delayed and possibly cut short while you fill it out.
2. **CHILDREN**: If your child is under the age of 18, s(he) *must* be accompanied by an adult.
3. **PAYMENT POLICY:** Full payment is due at the time of service. ***We do not bill insurance***. We accept cash, check, or credit card.
4. **CANCELLATION POLICY:** 24-hour notice is required for all cancellations. There is a charge for all missed appointments.
5. **PLEASE**: DO NOT WEAR PERFUME OR COLOGNE (As a courtesy, many of our clients and staff are chemically sensitive).

FOR HOLISTIC NURSING & BIONETIC APPOINTMENTS:

Your first visit will take approximately 1 to 2 hours.

Please bring:

1. All supplements and/or medications you are currently taking.
2. A sample of the water you drink (in a jar with a lid).

FOR CHIROPRACTIC CARE:

Your initial evaluation will take approximately 45 - 60 minutes.

FOR MASSAGE/CRANIAL SACRAL/VISCERAL MANIPULATION:

Appointment times range from 30 minutes to 2 hours, as scheduled. It is best to wear ***loose*** clothing.

VISCERAL MANIPULATION:

- Do not eat prior to coming (2 hrs)
- Do not wear under-wire bras
- Please, wear ***VERY LOOSE***, comfortable clothing

FOR COUNSELING SERVICES:

Appointments range from 1 to 2 hours, as scheduled. Please come 15 minutes before each scheduled appointment time to fill out questionnaire provided by your practitioner. You may also download this off our website. Please bring forms with you at the time of your appointment. Thank you for preparing for your visit with us.

We look forward to working with you as you experience more abundant health, a heightened sense of well-being and greater emotional freedom. We truly believe *"Where there is an open mind and a willing heart, there is a path to healing."*

ADVANCED HEALTH CLINIC AND THERAPEUTIC SPA

Where there is an open mind and a willing heart, there is a path to healing

630 W Shepard Lane, Farmington, UT 84025 • 801-447-8680 • appt@AdvancedHealthClinic.com • www.AdvancedHealthClinic.com

Today's Date:

CLIENT INFORMATION

(Please Print)

LAST NAME:	FIRST:	MIDDLE INITIAL:	AGE:	DATE OF BIRTH:

ADDRESS:
CITY:
STATE:
ZIP CODE:

SEX: ☐ M ☐ F

MARITAL STATUS (CIRCLE ONE):
MARRIED WIDOWED DIVORCED SINGLE SIGNIFICANT OTHER

EMAIL (WE WILL *NEVER* DISTRIBUTE OR SELL YOUR INFORMATION):

HOME PHONE:	CELL NUMBER:

OCCUPATION:	EMPLOYER:	EMPLOYER PHONE:

NAME OF PERSON WHO REFERRED YOU:

PAYMENT POLICY

PERSON RESPONSIBLE FOR BILL: IS THIS PERSON A CLIENT AT ADVANCED HEALTH CLINIC? ❑ YES ❑ NO
ADDRESS (IF DIFFERENT):

HOME PHONE (IF DIFFERENT):	CELL /WORK PHONE:

_____ (Please Initial) I understand it is a courtesy to provide 48-hour notice (2 business days) in the event I need to cancel an appointment. If I am unable to provide 24-hour (1 business day) notice for any cancellation, I understand I will be charged for my missed appointment. (We *never* like having to do this so *please* call – Thank you!)

_____ (Please Initial) I understand that payment for all fees are payable to Advanced Health Clinic, LLC, (AHC) in behalf of practitioner or entity by cash, check, or major credit card at the time services are rendered. If your check is returned unpaid, your account will be debited electronically for the original amount and electronically or via paper for the state's maximum allowable service fee. Payment by check constitutes authorization of these transactions. I further understand that 21% interest/annum for accounts 30 days past due. I further understand that payment is due at the time of, or previous to, services being rendered by cash, check, Visa, MasterCard, Discover, or a debit card. I understand AHC will never bill insurance nor file insurance claims.

IF YOU WILL BE HAVING US SHIP ANYTHING TO YOU, OR PAYING FOR A CHILD OR SOMEONE ELSE WHEN YOU ARE NOT HERE, PLEASE PROVIDE THE FOLLOWING INFORMATION:

I authorize Advanced Health Clinic to charge the following credit card account for services received at Advanced Health Clinic:
Please Sign: ✗_____

CREDIT CARD TYPE: V D MC DEBIT LAST 4 DIGITS OF CARD TO BE USED: XXXX XX _ _ _ _ (*PLEASE PROVIDE ENTIRE NUMBER TO FRONT DESK*)

IN CASE OF EMERGENCY CONTACT:

NAME OF LOCAL FRIEND OR RELATIVE:	HOME PHONE:
RELATIONSHIP TO CLIENT:	CELL/WORK PHONE:

HIPAA NOTICE OF CLIENT PRIVACY PRACTICES

Your health information is private and protected by law. Your information will only be used or disclosed for the purpose of giving care, billing, or supporting day to day operations. You have the right to review your file. You may restrict all or part of your health information from being released, as allowable by law. If you request information to be transmitted electronically, please be advised that your private information may not be protected. Advanced Health Clinic transmits from a secure, encrypted network server, however, we cannot guarantee that any information you receive from AHC or your practitioner will be received through a secure network on your end. We will take every step necessary on our end to protect your privacy. A more detailed version of our privacy policies are available online or at Advanced Health Clinic, LLC (AHC). If you choose to contact us or your practitioner by electronic means, (ie: website, facebook, social media, text, email, etc), you understand that this is not a secured form of communication and your private health information may not be protected, and by contacting us via those means, you are waiving your Privacy Rights. Advanced Health Clinic cannot guarantee your information remains protected during electronic communication.

_____ (Please Initial) *I have received a HIPAA NOTICE OF CLIENT PRIVACY PRACTICES (see above). I have had a chance to ask questions about privacy policies and I give my permission to this office to disclose my name and, or protected health information in accordance with such policies. I allow my health Information to be shared among practitioners at Advanced Health Clinic, LLC, for the purpose of giving care. I further understand that my chart will always remain the property of and in the care of AHC. I give permission for my picture to be kept on file for identification purposes.*

INFORMED CONSENT
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

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 a medical diagnostic tool, nor is it used for that purpose. I further understand that the use of a BioCommunication device by the Providers may NOT, and is NOT, used for the purpose of diagnosing, recommending, or prescribing any Treatment for, or for Treating, any symptom, condition, disease, or illness.

_____ **(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.

INFORMED CONSENT
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

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.






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INFORMED CONSENT

_____ (Please Initial) By signing below, I am verifying that I have read this informed consent and I understand it. I am not a minor (under the age of 18). Additionally, I am here on this day and any subsequent visit, solely on my own behalf and not as an agent for any federal, state, or local agencies on a mission of entrapment or investigation and I also certify that I am signing my own true given, legal name and not an alias or false name.

_____ (Please Initial) I understand that I have sought services provided through Independent Contractors at Advanced Health Clinic, LLC (AHC) for my personal wellness care or for my child or children who are minors. I understand that each and every practitioner I (they) see is a separate entity that leases from AHC and operate independently as practitioners and/or companies. I further understand that Therapeutic Spa, LLC and Health & Nutrition, LLC, are separate entities from Advanced Health Clinic, LLC (AHC). I further understand that a Practitioner and/or Entity that has their practice at AHC may specialize and employ methods that may be considered to be "unconventional" and/or "unorthodox", also known as "alternative", "integrative", "holistic" and/or "complimentary" medicine.

_____ (Please Initial) I understand that AHC provides services for Independent Contractors and is exclusively an office-based practice. I recognize AHC is not affiliated with a local hospital. I further understand that **AHC STRONGLY RECOMMENDS IN ADDITION TO ANY CARE RECEIVED AT AHC AND/OR AN INDEPENDENT CONTRACTOR THROUGH AHC, THAT I MAINTAIN A RELATIONSHIP WITH ONE OR MORE PHYSICIANS QUALIFED TO CARE FOR MY MEDICAL CONDITION(S).** For example, in the case of children AHC advises that I seek the advice of a pediatrician; if I have cardiovascular disease I consult with a cardiologist; if I have mental illness, I consult with a mental health specialist; and if I have cancer I consult with an oncologist, etc.

_____ (Please Initial) I understand that AHC and/or its employees, and/or its representatives make no representations, claims, or guarantees regarding the efficacy of a practitioner's practice, recommendations, treatments, procedures, or therapeutic services. I further acknowledge that I understand that any service and/or therapy I receive MAY alter, address, or decrease my pain, symptoms, or complaints, but also may have no effect at all.

_____ (Please Initial) **CONFLICT RESOLUTION:** By signing this informed consent I consent and agree to hold harmless, Advanced Health Clinic, LLC (AHC), and/or their staff and/or employees, and/or associated entities from all professional and personal liability. I further understand and consent that that all services and/or therapies are patient and/or client directed therapies and I will direct my practitioner and/or staff to perform any therapy and/or service I receive at AHC. In doing so I, and any and all parties that may represent me or my estate, hold harmless Advanced Health Clinic, LLC, the practitioner, and/or staff and all other controlling or involved entities or manufacturers.

In the event I or my representative or heirs bring a legal case against AHC, I agree to be responsible for all legal costs and fees that may result from action(s) on my part or on the part of my representatives(s) against AHC or its representative(s). I agree that AHC shall be judged by the standards and principles of holistic/alternative/complimentary health care. I agree to settle any claim, dispute, or disagreement I have with Advanced Health Clinic and or Practitioners and/or Staff in person. If this is not possible, then I agree to enter into good faith non-binding mediation with Peacemaking and Conflict Resolution Services (PMCRS) as mediator, or if PMCRS is not available, I agree to meet with another mediator located in Farmington, Davis County, Utah or the surrounding area. If we are unable to settle via mediation, I further understand that any claim or dispute arising under or out of this Agreement shall be subject to binding arbitration pursuant to the Commercial Rules of the American Arbitration Association (AAA) and conducted in the City of Farmington, Utah, or within the surrounding area. There shall be a single arbitrator selected by the AAA. In no event shall either party be entitled to punitive damages. The parties shall split the cost of mediating and disputing equally. Any attorney's fees incurred during the mediation shall become a subject of the mediation and the parties will attempt to resolve attorney's fees during the mediation. The costs of binding arbitration shall be split between the parties equally and the arbitrator. Each party is responsible for their own attorney fees for arbitration.

I further understand and consent that I have the right to have this consent reviewed by my lawyer before accepting any medical, wellness care, and/or nutritional services from Advanced Health Clinic, LLC. Although AHC and/or the staff and/or practitioner will not be able to provide any professional services to clients and or patients who choose not to sign, we will provide any medical records we have in our possession to you so that you can select the healthcare practitioner of your choice for your continued care.

_____ (Please Initial) **SEVERABILITY:** If any term, provision or condition of this Agreement, or any application thereof, should be held by a court of competent jurisdiction to be invalid, void, or unenforceable, all provisions and conditions of this Agreement and all applications thereof not held invalid, void or unenforceable, shall continue in full force and effect and shall in no way be affected, impaired or invalidated thereby, by entering my signature below I am acknowledging that I understand all terms, verbiage (language) and concepts herein.

I hereby consent to and authorize the above understandings of this Informed Consent for me and/or my child(ren). I have executed this agreement freely and willingly.

Client Name (Please Print) _____ Signature _____Date_____

Parent or Guardian signature if under 18_____ Date_____

Witness _____Date _____

INFORMED CONSENT

HEALTH & NUTRITION, LLC
630 W. Shepard Lane
Farmington, UT 84025
Phone: 801-447-8680 FAX: 801-447-4211

GENERAL UNDERSTANDING: I understand that Health & Nutrition, LLC, (H & N), is **an independent entity** who leases from Advanced Health Clinic, LLC (AHC). I understand that the primary business of H & N is to make available for purchase holistic and natural items including herbs, homeopathy, nutrients, whole foods, diodes, cd's', books, etc.

_____ (Please Initial) I understand that by signing this informed consent that I agree and understand that all supplements purchases are client directed purchases. I further understand, agree, and consent that in doing so I, and any and all parties that may represent me or my estate, hold harmless Health & Nutrition, LLC, Advanced Health Clinic and/or other controlling or involved entities or manufacturers from all professional and personal liability regarding any injury or harm that I may receive from services or purchase made from Health & Nutrition, LLC or Advanced Health Clinic, LLC. I further understand that Health and Nutrition, LLC, and/or Advanced Health Clinic, LLC and/or its employees, and/or its representatives make no representations, claims, or guarantees regarding the efficacy of Nutritional Supplements, or its services. I additionally understand that I am not required to purchase from H & N any supplement or nutritional recommendation made by any practitioner, employee, or representative who works at/or for AHC. I further understand that no profit is received by any recommendation that an employee and/or practitioner makes to me. I further understand that supplements are not meant to replace adequate medical care or pharmaceutical recommendations made by my physician. I understand and acknowledge that any **suggestion or recommendation made to me has not been prescribed to me for the treatment of any known or unknown medical disease or illness by anyone.** I further understand that any recommendation made to me by a practitioner and/or staff member are simply that, a recommendation. Any purchase I make is of my own free will.

_____ (Please Initial) I further understand that a BioCommunication device(s) is NOT a medical device, nor does it provide any diagnostic information. It is NOT a diagnostic tool, nor should I use a BioCommunication scan for that purpose. I understand that a BioCommunication "scan" is a client-directed service.. I further understand that BioCommunication (such as ZYTO technology) is referred to as wellness decision support technology. BioCommunication and/or ZYTO scans are not intended to treat or diagnose disease or illness.

PAYMENT POLICY: I understand that payment is due at time of service and that all fees are payable to Advanced Health Clinic, LLC, in behalf of Health & Nutrition, LLC by cash, check, or major credit card at the time services are rendered. In the event of a returned check, I will reimburse Advanced Health Clinic, LLC the total of the check by cash or credit card with an additional $25 service fee and 21% interest/annum for accounts 30 days past due**.**

By entering my signature below I am acknowledging that I understand all terms, verbiage (language) and concepts herein. I hereby consent to and authorize the above understandings for me and/or my child(ren). I have executed this agreement freely and willingly. (Please Sign below):

Client Name (Please Print) _____

Signature x_____**Date**_____

Parent or Guardian signature if under 18_____Date_____

Witness _____Date _____

INFORMED CONSENT

THERAPEUTIC SPA, LLC
630 W. Shepard Lane
Farmington, UT 84025
Phone: 801-447-8680 FAX: 801-447-4211

GENERAL UNDERSTANDING: I understand that Therapeutic Spa, LLC, (TS), is an **independent entity** who leases from Advanced Health Clinic, LLC (AHC).

I understand that the primary business is to offer **therapeutic spa services** available to clients who come to AHC. I **understand that Therapeutic Spa, LLC, AHC and/or its employees, and/or its representatives make no representations, claims, or guarantees regarding the efficacy of therapeutic spa treatments, procedures, or services. I understand that by signing this informed consent I agree to hold harmless, Therapeutic Spa LLC and its employees and/or representatives from all professional and personal liability regarding any injury or harm that I receive while visiting and/or receiving treatment from services at Therapeutic Spa, LLC.**

PAYMENT POLICY: I understand that payment is due at time of service and that all fees are payable to Advanced Health Clinic, LLC, in behalf of Therapeutic Spa, LLC by cash, check, or major credit card at the time services are rendered. In the event of a returned check, I will reimburse Advanced Health Clinic, LLC the total of the check by cash or credit card with an additional $25 service fee and 21% interest/annum for accounts 30 days past due ,

By entering my signature below I am acknowledging that I understand all terms, verbiage (language) and concepts herein. I hereby consent to and authorize the above understandings for me and/or my child(ren). I have executed this agreement freely and willingly. (Please Sign below):

Client Name (Please Print) _____

Signature x_____**Date**_____

Parent or Guardian signature if under 18_____Date_____

Witness _____Date _____

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Fee Acknowledgment

Preventative medicine, integrative medicine, holistic medicine, alternative medicine, bio-identical hormone replacement, IV nutritional therapy, chiropractic care, along with most services offered at the clinic are a unique practice and are considered a form of alternative medicine. Even though our practitioners are licensed and board certified, insurance does not recognize it as necessary medicine BUT is considered complimentary medicine and therefore is not covered by health insurance in most cases.

Advanced Health Clinic, LLC (AHC) (as well as any Practitioner who practices at AHC) is not associated with any insurance company, which means insurance companies are not obligated to pay for services you receive at Advanced Health Clinic (blood work, consultations, therapies, treatments, labs, IV's, insertions or pellets). We require payment at time of service and, if you choose, we will provide a receipt showing that you paid out of pocket and what the visit was for. WE WILL NOT, however, communicate in any way with insurance companies or Health Savings Plans. This is not a guarantee that those services will be paid for by your insurance company. Many of the services provided at AHC and/or by Independent Contractors (Practitioners) do not have medical billing codes.

For clients who have access to a Health Savings Account, some of your appointments may qualify for use with that credit or debit card. Please check with your plan to see what they will cover prior to using your Health Savings Account for your visit. If your plan covers those services and you wish to put it on your Health Savings Account, please inform your practitioner prior to the beginning of your appointment so that they prepare your receipt accordingly. Even then, this does not guarantee that your Health Savings Account will accept your claim. Most Health Savings Accounts will not cover supplements, vitamins, or minerals.

The form and receipt are your responsibility and serve as evidence of your treatment. We will not call, write, pre-certify, or make any contact with your insurance company. Any follow up letters from your insurance to us will be thrown away. If we receive a check from your insurance company, we will not cash it, but instead return it to the sender. Likewise, we will not mail it to you. We will not respond to any letters or calls from your insurance company.

We accept the following forms of payment:

Master Card, Visa, Discover, Personal Checks and Cash.

By signing below, I hereby acknowledge receipt and understanding of AHC Fee Policy:

x_____ _____ _____

Print Name **Client Signature** **Date Signed**

INFORMED CONSENT
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

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 a medical diagnostic tool, nor is it used for that purpose. I further understand that the use of a BioCommunication device by the Providers may NOT, and is NOT, used for the purpose of diagnosing, recommending, or prescribing any Treatment for, or for Treating, any symptom, condition, disease, or illness.

_____ **(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.

INFORMED CONSENT
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

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.

NON-MEDICARE PROVIDER AGREEMENT
(Fill out if you are on Medicare)

This agreement is between Martha Bray, FNP-BC, APRN ("Physician"), whose principal place of business is 630 W. Shepard Lane, and patient _____ ("Patient"), who resides at

_____ and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Patient that Physician has opted out of the Medicare program effective on 6/8/2011 for a period of at least two years, and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

Martha Bray, FNP-BC, APRN agrees to provide the following medical services to Patient (the "Services"):

Any and all services provided by AHC II, Inc. and Martha L. Bray, FNP-BC, APRN

In exchange for the Services, the Patient agrees to make payments to Physician pursuant to the Attached Fee Schedule. Patient also agrees, understands and expressly acknowledges the following:

- Patient agrees **not to submit a claim** (or to request that Physician submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.
- Patient is not currently in an emergency or urgent health care situation.
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.
- Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
- Patient acknowledges that he has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.
- Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services, and acknowledges that **Physician will not submit a Medicare claim** for the Services and that no Medicare reimbursement will be provided.
- Patient understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.
- Patient acknowledges that a copy of this contract has been made available to him.
- Patient agrees to reimburse Physician for any costs and reasonable attorneys' fees that result from violation of this Agreement by Patient or his beneficiaries.

Executed on _____(date) by _____ (Name)

and Martha Bray, FNP-BC, APRN for AHC II, Inc.

_____ _____

[Patient signature] [Witness signature]

Health Profile

Dietary consultation involves a health profile whose purpose is not to establish a diagnosis, but rather to determine a client's health status in order to guide his or her weight-loss plan. A client may be advised to seek medical advice based on his or her health profile.

NPA - Needs Prescriber Approval NPC - Needs Prescriber Care

General

Last Name: _____ First Name: _____

Date of Birth: _____ Age: _____

Whom may we thank for referring you?

Weight 1 year ago: ____ lbs. Min. Adult Weight: _____ lbs at age _____

Maximum Weight: _____ lbs. at age _____ Height: _____ Goal Weight: _____

Have you been on a diet before? □ Yes □ No _____

If yes, please specify which diet and why you think it didn't work for you (e.g. too rigid, too much cooking involved, etc.): _____

_____

_____

_____

On a scale of 1 to 10, indicate what level of importance you give to losing weight via Martha's Therapeutic LifeStyle Plan™ medically supervised weight loss method or doing a medically supervised detoxification program (10 being the most important): _____

Medical Information:

Please list any physicians you see and their specialty:

_____

_____

_____

_____

Health Profile

***Diabetes*:**

Do you have diabetes? □ Yes □ No

If so, are you under the care of a physician? □ Yes □ No

If so, which type?

□ Type I – insulin dependent (insulin injections only)
□ Type II – non-insulin dependent (diabetic pills)
□ Type II – insulin dependent (diabetic pills and insulin)

Do you tend to be hypoglycemic? □ Yes □ No
Is your blood sugar level monitored? □ Yes □ No

If so, by whom? □ Myself □ Physician □ Other (specify):

_____

Are you taking any medication? □ Yes □ No
If so, please list: _____

NOTE: If you are currently on Sodium-Glucose Co-Transporter inhibitor medication (SGLT-2), which include Ebymect, Edistride, Forxiga, Invokana, Jardiance, Synjardy, Vokanamet and Xigduo, YOU CANNOT START OR BE ON SPECIFIC PROTOCOLS. Please speak to your coach.

***Cardiovascular Health*:**

Have you had any of the following conditions?

□ Yes Arrhythmia (NPA)
□ Yes Blood Clot (NPA)
□ Yes Coronary Artery Disease (NPA)
□ Yes Heart attack (NPC)
□ Yes Heart Valve Problem (NPA)
□ Yes Heart Valve Replacement (porcine/mechanical) (NPA)
□ Yes History of Congestive Heart Failure
□ Yes Hyperlipidemia Please select one (if applicable):
(High cholesterol/triglycerides)
□ Yes Hyperkalemia (High potassium) (NPA)
□ Yes Hypokalemia (Low potassium) (NPA)
□ Yes Hypertension (High blood pressure) (NPA)
□ Yes Pulmonary Embolism (NPA)
□ Yes Stroke or Transient Ischemic Attack (NPA)
□ Yes Congestive Heart Failure (NPC)
□ Yes Current Congestive Heart Failure (NPC)

Have you ever had any type of heart surgery? □ Yes □ No
If so, which type?

_____
_____

Have you had a cardiovascular event? □ Yes □ No (if no, skip to next section)
If so, please specify:

_____

How long ago?

_____

If so, are you under the care of a physician? □ Yes □ No
Are you taking any medication? □ Yes □ No
If so, please list:

_____

Health Profile

***Hypertension*:**

□ Yes Do you have high blood pressure?
□ Yes If so, do you have your blood pressure checked regularly?

□ Yes If so, are you under the care of a physician?
□ Yes Are you taking any medication?
If so, please list:

_____

Kidney Health:

□ Yes Have you been diagnosed with kidney disease?
□ Yes Have you had a kidney transplant?
□ Yes Have you had kidney stones?
□ Yes Have you ever had Gout?

□ Yes If so, are you under the care of a physician?
□ Yes Are you taking any medication?
If so, please list:

_____

Liver Health:

□ Yes Do you have liver problems?
If yes, please give details:

_____

□ Yes Have you ever had a gallstone event?
If so, please specify:

_____

□ Yes □ No If so, are you under the care of a physician?
□ Yes □ No Are you taking any medication?
If so, please list:

_____

***Colon, Stomach and Digestive Health*:**

Do you have any of the following conditions:

□ Yes Acid Reflux
□ Yes Celiac Disease
□ Yes Irritable Bowel
□ Yes Diarrhea
□ Yes Gastric Ulcer (NPA)
□ Yes History of Bariatric Surgery (NPA)

□ Yes Gluten intolerance
□ Yes Heartburn
□ Yes Colitis
□ Yes Constipation
□ Yes Diverticulosis

If so, are you under the care of a physician? □ Yes □ No
Are you taking any medication? □ Yes □ No
If so, please list:

_____

Health Profile

Ovarian/Breast Health:

Check off the situations that apply to you currently:

□ Irregular Periods	□ Menopause	□ Fibrocystic Breasts
□ Painful Periods	□ Hysterectomy	□ Heavy periods
□ Amenorrhea	□ Uterine fibroma	□ Cancer (uterus, breast)

If so, are you under the care of a physician? □ Yes □ No
Are you taking any medication? □ Yes □ No
If so, please list:

_____

Please indicate the date of your last menstrual cycle: _____

Are you:

□ Yes Breastfeeding/Nursing □ Yes Pregnant

***Endocrine Function*:**

Do you have thyroid problems? □ Yes □ No
If so, please specify:

_____

Do you have parathyroid problems? □ Yes □ No
If so, please specify:

_____

Do you have adrenal gland problems? □ Yes □ No
If so, please specify:

_____

Have you been told you have Metabolic Syndrome? □ Yes □ No

If so, are you under the care of a physician? □ Yes □ No
Are you taking any medication? □ Yes □ No
If so, please list:

_____

***Neurological Emotional Evaluation*:**

Do you have any of the following conditions:

Alzheimer's disease	□ Yes □ No	Depression	□ Yes □ No
Anorexia (History of)	□ Yes □ No	Epilepsy (NPA)	□ Yes □ No
Anxiety	□ Yes □ No	Panic attacks	□ Yes □ No
Bipolar disorder	□ Yes □ No	Parkinson's disease	□ Yes □ No
Bulimia (History of)	□ Yes □ No	Schizophrenia	□ Yes □ No

Are you taking any medication? □ Yes □ No
If so, please list:

_____

Health Profile

Inflammatory Conditions:

Do any of the following apply to you? (if no, skip to next section)
□ Migraines □ Fibromyalgia □ Rheumatoid Arthritis □ Lupus □ Psoriasis
□ Osteoarthritis □ Chronic Fatigue Syndrome □ Other autoimmune or inflammatory condition:

_____

If so, are you under the care of a physician? □ Yes □ No
Are you taking any medication? □ Yes □ No
If so, please list:

_____

Cancer:

Do you have cancer? (NPC) □ Yes □ No If so, what type and where is it located?

_____

Have you ever had cancer? (NPC) □ Yes □ No If so, what type and where is it located?

_____

Is your cancer in remission? (NPC) □ Yes □ No
If so, how long have you been in remission? (mm/yy) _____

If so, are you under the care of a physician? □ Yes □ No
Are you taking any medication? □ Yes □ No
If so, please list:

_____

Allergies:

Do you have any **food** allergies? □ Yes □ No
If so, please list: _____

Do you have any **medication** allergies? □ Yes □ No
If so, please list: _____

General:

Do you get cold easily? □ Yes □ No Do you have cold hands/feet? □ Yes □ No

Do you have other health problems? □ Yes □ No
If so, please specify: _____

If so, are you under the care of a physician? □ Yes □ No
Are you taking any other medications not listed above? □ Yes □ No
If so, please list:

_____

_____

Are you currently taking Vitamins, Herbs, Homeopathics or Supplements? □ Yes □ No
Please list and Reason for:

_____

_____

_____

If you have health problems not indicated on this health profile, please consult your physician

Health Profile

Informed Consent and Complete Health Disclosure by Client Agreement

I confirm that the information that I have provided to Advanced Health Clinic, LLC service provider (the "Clinic") and that the information that is recorded by me on Martha's Therapeutic LifeStyle Plan™Health Profile is true, complete and accurate and that I have not withheld or otherwise omitted, whether in whole or in part, any information concerning my health status. In this respect, I confirm that I have disclosed all past and present i) physical and/or mental health problems or concerns that I have experienced, ii) diagnoses and/or surgeries that I have had, and iii) medications and supplements that were prescribed to me or that I have taken.

Without limitation to the foregoing, I specifically confirm that I do not have any of the conditions and that I am not taking any of the medications specifically highlighted in purple / identified as NPC or NPA on this form. Furthermore, I understand that I should not be undertaking or otherwise following Martha's Therapeutic LifeStyle Plan™ protocols if I have any of the said conditions or if I am currently taking any of the said medications unless i) I specifically consult with a medical doctor concerning my suitability to go on the Martha's Therapeutic LifeStyle Plan™ Protocols, ii) remain under the supervision of said medical doctor while I am on the Martha's Therapeutic LifeStyle Plan™ Protocols, and iii) provide documentation confirming the foregoing. I understand that if i) I have any of the aforementioned conditions or if I am currently taking any of the aforementioned medication, ii) have not disclosed same to the Clinic and iii) nevertheless chose to follow on the Martha's Therapeutic LifeStyle Plan™Protocols without specific supervision, such decision will be completely voluntary, and I, for myself and my successors, release and discharge the Clinic as well as AHC II, Inc., Health and Nutrition, LLC, Therapeutic Spa, LLC, their parent companies, subsidiaries and affiliates and each of their respective shareholders, directors, employees, agents, representatives, successors and assigns (collectively, the "Releasees") from any and all damages, liability, claims and causes of action of any nature whatsoever (including for injury, illness or death) that may result from such voluntary and informed decision of following the Martha's Therapeutic LifeStyle Plan™Protocols. I confirm that Martha's Therapeutic LifeStyle Plan™Protocols have been explained to me, that I have had the opportunity to ask questions relating to Martha's Therapeutic LifeStyle Plan™ Protocols, that I have been provided with the answers to such questions and that I understand the importance of strictly following the Martha's Therapeutic LifeStyle Plan™ Protocol as explained to me verbally and in the materials provided to me, both before and during the period I will be following Martha's Therapeutic LifeStyle Plan™ Protocols.

Without limitation to the foregoing, I confirm that I have been advised that because Martha's Therapeutic LifeStyle Plan™Protocols may limit the ingestion of certain foods, it is important that I consume the recommended vitamins and minerals while I am on Martha's Therapeutic LifeStyle Plan™Protocol.

I undertake to disclose immediately to the Clinic any and all changes in my health status, discomfort, symptoms or other health concerns that I may experience while I am following the Martha's Therapeutic LifeStyle Plan™ Protocol. I specifically agree that all claims against any of the Releasees that I may have or choose to make shall only be submitted to binding arbitration under the rules of the Arbitration Act or similar statute of my state of residence, and I waive any rights to pursue any claims or causes of action in any court of law.

Signature: _____ Date: _____

Witness: _____ Date: _____

The signatory client hereby recognizes the veracity of the information provided herein and that he/she has made an informed decision to go on *Martha's Therapeutic LifeStyle Plan*, which may include the Ideal Protein, Metagenics Clear Choice, First Line Therapy Detox and Weight Loss Protocols, Designs for Health Paleo Plus Detox and Weight Loss Protocols, and Designs for Health Comprehensive Detox and/or OptiLean Protocols.

Confirmation of full health status disclosure by the client and agreement to arbitrate disputes

I confirm that the information that I have provided to my Ideal Protein™ Protocol service provider (the "**Clinic**") and that is recorded by me on this Ideal Protein™ Health Profile is true, complete and accurate and that I have not withheld or otherwise omitted, whether in whole or in part, any information concerning my health status. In this respect, I confirm that I have disclosed all past and present i) physical and/or mental health problems or concerns that I have experienced, ii) diagnoses and/or surgeries that I have had, and iii) medications and supplements that were prescribed to me or that I have taken.

Without limitation to the foregoing, I specifically confirm that I do not have any of the **conditions** and that I am not taking any of the **medications specifically highlighted in purple / identified as NPC or NPA on this form.** Furthermore, I understand that I should not be undertaking or otherwise following the Ideal Protein™ Protocol if I have any of the said conditions or if I am currently taking any of the said medications unless i) I specifically consult with a medical doctor concerning my suitability to go on the Ideal Protein™ Protocol, ii) remain under the supervision of said medical doctor while I am on the Ideal Protein™ Protocol, and iii) provide documentation confirming the foregoing.

I understand that if i) I have any of the aforementioned conditions or if I am currently taking any of the aforementioned medication, ii) have not disclosed same to the Clinic and iii) nevertheless chose to follow on the Ideal Protein™ Protocol without specific supervision, such decision will be completely voluntary, and I, for myself and my successors, release and discharge the Clinic as well as Ideal Protein of America Inc., their parent companies, subsidiaries and affiliates and each of their respective shareholders, directors, employees, agents, representatives, successors and assigns (collectively, the "**Releasees**") from any and all damages, liability, claims and causes of action of any nature whatsoever (including for injury, illness or death) that may result from such voluntary and informed decision of following the Ideal Protein™ Protocol.

I confirm that the Ideal Protein™ Protocol has been explained to me, that I have had the opportunity to ask questions relating to the Ideal Protein™ Protocol, that I have been provided with the answers to such questions and that I understand the importance of strictly following the Ideal Protein™ Protocol as explained to me verbally and in the materials provided to me, both before and during the period I will be following the Ideal Protein™ Protocol.

Without limitation to the foregoing, I confirm that I have been advised that because the Ideal Protein™ Protocol limits the ingestion of certain foods, it is important that I consume the recommended vitamins and minerals while I am on the Ideal Protein™ Protocol.

I undertake to disclose immediately to the Clinic any and all changes in my health status, discomfort, symptoms or other health concerns that I may experience while I am following the Ideal Protein™ Protocol.

I specifically agree that all claims against any of the Releasees that I may have or choose to make shall only be submitted to binding arbitration under the rules of the Arbitration Act or similar statute of my state of residence, and I waive any rights to pursue any claims or causes of action in any court of law.

Signed in _____ (city/state), on this _____ day of _____, 20_____.

Name of witness (print): _____

Name of client (print) _____

_____ _____

Client Signature Witness Signature

Last name: _____ First name: _____ DOB: _____ (DD/MM/YY) Initials: _____

DETOXIFICATION QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Rate each of the following symptoms based on your typical health profile for the specified duration:

❒ Past month ❒ Past week ❒ Past 48 hours

Point Scale: **0**—*Never or almost never* have the symptom **1**—*Occasionally* have it, effect is *not severe* **2**—*Occasionally* have it, effect is *severe*
3—*Frequently* have it, effect is *not severe* **4**—*Frequently* have it, effect is *severe*

I. Medical Symptoms Questionnaire (MSQ)

HEAD	_____	Headaches	
	_____	Faintness	
	_____	Dizziness	
	_____	Insomnia	**TOTAL** _____
EYES	_____	Watery or itchy eyes	
	_____	Swollen, reddened or sticky eyelids	
	_____	Bags or dark circles under eyes	
	_____	Blurred or tunnel vision	**TOTAL** _____
EARS	_____	Itchy ears	
	_____	Earaches, ear infections	
	_____	Drainage from ear	
	_____	Ringing in ears, hearing loss	**TOTAL** _____
NOSE	_____	Stuffy nose	
	_____	Sinus problems	
	_____	Hay fever	
	_____	Sneezing attacks	
	_____	Excessive mucus formation	**TOTAL** _____
MOUTH/ THROAT	_____	Chronic coughing	
	_____	Gagging, frequent need to clear throat	
	_____	Sore throat, hoarseness, loss of voice	
	_____	Swollen or discolored tongue, gums, lips	
	_____	Canker sores	**TOTAL** _____
SKIN	_____	Acne	
	_____	Hives, rashes, dry skin	
	_____	Hair loss	
	_____	Flushing, hot flashes	
	_____	Excessive sweating	**TOTAL** _____
HEART	_____	Chest pain	
	_____	Irregular or skipped heartbeat	
	_____	Rapid or pounding heartbeat	**TOTAL** _____
LUNGS	_____	Chest congestion	
	_____	Asthma, bronchitis	
	_____	Shortness of breath	
	_____	Difficulty breathing	**TOTAL** _____
DIGESTIVE TRACT	_____	Nausea, vomiting	
	_____	Diarrhea	
	_____	Constipation	
	_____	Bloated feeling	
	_____	Belching, passing gas	
	_____	Heartburn	
	_____	Intestinal/stomach pain	**TOTAL** _____
JOINTS/ MUSCLE	_____	Pain or aches in joints	
	_____	Arthritis	
	_____	Stiffness or limitation of movement	
	_____	Feeling of weakness or tiredness	
	_____	Pain or aches in muscles	**TOTAL** _____
WEIGHT	_____	Binge eating/drinking	
	_____	Craving certain foods	
	_____	Excessive weight	
	_____	Water retention	
	_____	Underweight	
	_____	Compulsive eating	**TOTAL** _____
ENERGY/ ACTIVITY	_____	Fatigue, sluggishness	
	_____	Apathy, lethargy	
	_____	Hyperactivity	
	_____	Restlessness	**TOTAL** _____
MIND	_____	Poor memory	
	_____	Confusion, poor comprehension	
	_____	Difficulty in making decisions	
	_____	Stuttering or stammering	
	_____	Slurred speech	
	_____	Learning disabilities	
	_____	Poor concentration	
	_____	Poor physical coordination	**TOTAL** _____
EMOTIONS	_____	Mood swings	
	_____	Anxiety, fear, nervousness	
	_____	Anger, irritability, aggressiveness	
	_____	Depression	**TOTAL** _____
OTHER	_____	Frequent illness	
	_____	Frequent or urgent urination	
	_____	Genital itch or discharge	**TOTAL** _____
GRAND TOTAL			**TOTAL** _____

II. Xenobiotic Tolerability Test (XTT)

1. Are you presently using prescription drugs?
❒ Yes (1 pt.)
If yes, how many are you currently taking? ____ (1 pt. each)
❒ No (0 pt.)

2. Are you presently taking one or more of the following over-the counter drugs?
❒ Cimetidine (2 pts.)
❒ Acetaminophen (2 pts.)
❒ Estradiol (2 pts.)

3. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them:
❒ Experience side effects, drug(s) is (are) efficacious at lowered dose(s) (3 pts.)
❒ Experience side effects, drug(s) is (are) efficacious at usual dose(s) (2 pts.)
❒ Experience no side effects, drug(s) is (are) usually not efficacious (2 pts.)
❒ Experience *no* side effects, drug(s) is (are) usually efficacious (0 pt.)

4. Do you currently use or within the last 6 months had you regularly used tobacco products?
❒ Yes (2 pts.) ❒ No (0 pt.)

5. Do you have strong negative reactions to caffeine or caffeine containing products?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

6. Do you commonly experience "brain fog," fatigue, or drowsiness?
❒ Yes (1 pt.) ❒ No (0 pt.)

7. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

8. Do you feel ill after you consume even small amounts of alcohol?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

10. Do you have a personal history of
❒ Environmental and/or chemical sensitivities (5 pts.)
❒ Chronic fatigue syndrome (5 pts.)
❒ Multiple chemical sensitivity (5 pts.)
❒ Fibromyalgia (3 pts.)
❒ Parkinson's type symptoms (3 pts.)
❒ Alcohol or chemical dependence (2 pts.)
❒ Asthma (1 pt.)

11. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?
❒ Yes (1 pt.) ❒ No (0 pt.)

12. Do you have an adverse or allergic reaction when you consume sulfite containing foods such as wine, dried fruit, salad bar vegetables, etc?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

GRAND TOTAL: _____

III. Alkalizing Assessment

1. Do you have a history or currently have kidney dysfunction?
❒ Yes ❒ No

2. Have you ever been diagnosed with a condition known as hyperkalemia?
❒ Yes ❒ No

3. Are you currently on diuretics or blood pressure medication?
❒ Yes ❒ No

Note: Prescribe non-alkalizing nutrients if patient answered yes to any part of this section.

For Practitioner Use Only:

OVERALL SCORE TABULATION

See doctor brochure for protocol suggestions.

MSQ SCORE _____ (High >50; moderate 15-49: Low <14)
XTT SCORE _____ (High >10; moderate 5-9: Low <4)
URINARY pH _____

Note: Patients with high MSQ but low XTT may be exhibiting pathology that is not related to toxic load. Other mechanisms should be considered such as inflammation/immune/allergic gastrointestinal dysfuntion, oxidative stress, hormonal/neuro-transmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet, and/or nutraceuticals.

FirstLineTherapy Health Profile

NAME _____ DATE _____

Rate each of the following symptoms based upon your typical health profile for: □ *Past 30 days* □ *Past 48 hours*

Point Scale				
	0	*Never* or *almost never* have the symptom	3	*Frequently* have it, effect is *not severe*
	1	*Occasionally* have it, effect is *not severe*	4	*Frequently* have it, effect is *severe*
	2	*Ocasionally* have it, effect is *severe*		

HEAD
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia
TOTAL

EYES
_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision
_____ (does not include near-
_____ or far-sightedness)
TOTAL

EARS
_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss
TOTAL

NOSE
_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation
TOTAL

MOUTH/ THROAT
_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums
_____ or lips
_____ Canker sores
TOTAL

SKIN
_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating
TOTAL

HEART
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain
TOTAL

LUNGS
_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing
TOTAL

DIGESTIVE TRACT
_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain
TOTAL

JOINTS / MUSCLE
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness
TOTAL

WEIGHT
_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight
TOTAL

ENERGY / ACTIVITY
_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness
TOTAL

MIND
_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities
TOTAL

EMOTIONS
_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression
TOTAL

OTHER
_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge
TOTAL

GRAND TOTAL