ADVANCED HEALTH CLINIC AND THERAPEUTIC SPA

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 2 to 3+ 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 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

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."*

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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 ☐ OTHER

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:
ADDRESS (IF DIFFERENT):

IS THIS PERSON A CLIENT AT ADVANCED HEALTH CLINIC? ❑ YES ❑ NO

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: ***X***_____

IN CASE OF EMERGENCY CONTACT:

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

HEALTH INFORMATION PRIVACY NOTICE

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 notice of 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.*

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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 _____

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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

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 _____

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]