GENERAL UNDERSTANDING:

_____ (Please Initial) I hereby acknowledge and understand that Martha L. Bray, 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. Martha Bray is an employee of AHC II, Inc., an Independent Contractor who leases from Advanced Health Clinic, LLC. I further understand that Martha L. Bray is licensed by the State of Utah to practice independently as a Family Nurse Practitioner. I further understand Martha L. Bray's consulting physician is Dr. Diane Farley-Jones. I further understand that Martha L. Bray, FNP-BC, APRN, AHN-BC, BCIM, specializes and employs methods that may be considered to be "unconventional" and/or "unorthodox", also known as "alternative", "integrative", "holistic" and/or "complimentary" medicine. I also understand that as a Family Nurse Practitioner, Martha Bray is a mid-level provider. I also further understand that I, or my representative (s), are responsible for my health care decisions. I understand if I have a serious illness and/or disease, Martha Bray highly recommends I consult and work with my physician and/or a specialist.

You are hereby notified that Martha L. Bray may utilize a BioCommunication device(s) and empower you through wellness coaching so you may make informed decisions about your life, health and wellness choices. ***You are hereby informed that BioCommunication devices are NOT a diagnostic tool, nor are they used for that purpose.***

_____ (Please Initial) ***I acknowledge that the use of a BioCommunication device does not constitute a medical diagnosis, that it is NOT a diagnostic tool and any BioCommunication device AHC II, Inc, Martha Bray and/or her representatives may use are NOT used for the purpose of diagnosing, recommending and/or used for the treatment of any disease or illness.***

_____ (Please Initial) **GENERAL CONSENT**: I understand, that, absent of an emergency or extraordinary circumstances, no procedures will be performed on me unless and until I have had an opportunity to discuss them. No procedures, medications or other health care treatments will proceed until I have, to my satisfaction, a full explanation. I have the right to consent, or refuse any proposed procedure or therapeutic course. I further understand that in the event of any adverse reaction after the first treatment that I will contact this clinic for further instructions. If it is a medical emergency, I will call 911.

DESCRIPTIONS OF TREATMENTS. You are hereby informed the Treatment (s) may include without limitation medical, diagnostic, nutritional treatment, NAET allergy reduction, BioIdentical Hormone Replacement Therapy, 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 your 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). You hereby are informed and understand that MAH, mAH, methods involves removing a small volume of your 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 the body intravenously, subcutaneously, or intramuscularly . The blood is also treated with a very small amount of temporary acting anti-coagulant (heparin). You are further informed that BPT involves removing a small volume of your 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).

The exact solution, treatment and site of injection for Your Treatment, as well as the recommended sequence of Treatments, will be explained to You when We actually administer the Treatments. You are further hereby informed that any of the above treatments may be administered by Martha Bray, and/or a nursing assistant, consultant or staff member. You are further hereby informed that no guarantees or promises as to the outcome or the safety and efficacy of any treatment plan or recommendation.

_____ (Please Initial) I hereby acknowledge and understand that the Treatment (s) may include without limitation medical, diagnostic, nutritional treatment, NAET allergy reduction, BioIdentical Hormone Replacement Therapy, 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 your 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 further acknowledge and understand that MAH, mAH, methods involves removing a small volume of your 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 the body intravenously, subcutaneously, or intramuscularly . The blood is also treated with a very small amount of temporary acting anti-coagulant (heparin). I further acknowledge and understand 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) I further acknowledge and understand that the exact solution, treatment and site of injection of my Treatment, as well as the recommended sequence of Treatments, will be explained to Me when I am actually administered the Treatments and that I consent to said treatments each and every time they are administered thereafter. I further acknowledge and understand and hereby consent that any of the above treatments may be administered by Martha Bray, and/or a nursing assistant, consultant or staff member. I further acknowledge and understand that no guarantees or promises as to the outcome or the safety and efficacy of any treatment plan or recommendation.

RISKS, SIDE EFFECTS, COMPLICATIONS. We hereby further inform you that the practice of wellness/preventative care/health care/medicine is not an exact science and that diagnosis and treatment may involve risk of injury or death. We hereby inform You that there are certain unavoidable risks and potential side effects and complications to Treatments, 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, internally and externally leaking fluid and scarring at injection sites (all of which except the leaking of fluid may be permanent); a feeling of “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; or other serious or debilitating injuries or death. You are further informed 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 (ie sulfa drugs, tetracyclines, phenothiazines) and the rare possibility of photoallergy in the case of allergy to sunlight.

_____ (Please Initial) I hereby acknowledge that I have been informed that the practice of wellness/preventative care/health care/medicine is not an exact science and that diagnosis and treatment may involve risk of injury or death. I further acknowledge there are certain unavoidable risks and potential side effects and complications to the Treatments, 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, internally and externally leaking fluid and scarring at injection sites (all of which except the leaking of fluid may be permanent); a feeling of “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; or other serious or debilitating injuries or death. I further acknowledge that I understand 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 (ie sulfa drugs, tetracyclines, phenothiazines) and the rare possibility of photoallergy in the case of allergy to sunlight.

EXPERIMENTAL NATURE OF TREATMENT. We hereby inform you that the evaluation, diagnosis, and treatments may consist in whole or part of experimental procedures and methods, including without limit all Treatments that have been addressed in this Informed Consent including but not limited to Intravenous Micronutrient Therapy, Prolotherapy, Ozone therapy and BPI, on 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 or efficacy thereof. I further acknowledge that the safety record of the Treatments is based only on empirical and anecdotal evidence, which only shows that the treatments appear to be relatively safe.

_____ (Please Initial) I acknowledge and agree that the evaluation, diagnosis, and treatments may consist in whole or part of experimental procedures and methods, including without limit all Treatments that have been addressed in this Informed Consent including but not limited to Intravenous Intravenous Micronutrient Therapy, Prolotherapy, Ozone therapy, and BPI, on 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 or efficacy thereof. I further acknowledge that the safety record of the Treatments is based only on empirical and anecdotal evidence, which only shows that the treatments appear to be relatively safe.

We hereby inform you that the Treatments MAY alter, address, or decrease your pain, symptoms, or complaints, but also may have no effect.

_____ (Please Initial) **I further acknowledge that I understand that the Treatments MAY alter, address, or decrease my pain, symptoms, or complaints, but also may have no effect at all.**

_____ (Please Initial) **CONSENT FOR TREATMENT.** I hereby consent to and authorized AHC II, Inc. and/or Martha Bray, FNP-BC, APRN, to provide me with health care and wellness treatments, which may include without limitation medical, diagnostic, nutritional treatment, intravenous Micronutrient Therapy, Prolotherapy and/or Prolozone, any form of Ozone Therapy, including, BPI, homeopathics, vitamins, minerals, amino acids, herbs, allergy serums, injections (e.g., intravenous, subcutaneous, intramuscular), detoxification programs, weight loss plans, nutritional plans, therapeutic spa therapies, any of which may be administered by Martha Bray, and/or a nursing assistant, consultant or staff member. I understand that the practice of health care/medicine is not an exact science and that diagnosis and treatment may involve risk of injury or death. I acknowledge that I have not been made any guarantees or promises as to the outcome or the safety and efficacy of the treatment. As a patient and/or client, I accept the risk of substantial and serious harm, I agree to make certain I understand and fully have all questions answered regarding my condition and the proposed health care plan in a satisfactory manner and that I am responsible to make certain that all questions have been asked about my health plan and its attendant risks have been answered in a manner satisfactory to the me or my representative before proceeding with any treatment plan.

_____ (Please Initial) I agree to provide, and will continue to provide, Martha Bray FNP-BC or her staff with a complete list of all prescription and non-prescription medications and dietary supplements I am currently taking, and I agree to update Martha Bray and her staff periodically should this list change. I have provided her with a complete list of all known allergies I may have, and all allergic or adverse reactions I have had in the past to any medicines, dietary supplements or medical treatments of any kind. I agree to keep Martha Bray and/or her staff updated with my current medical status before any treatment is performed. I covenant that all the information I provide Martha Bray and her staff during the course of Treatments, including without limitation the information required by this Section is true, accurate, complete, and up-to-date to the best of my knowledge.

_____ (Please Initial) I further understand and consent that all therapies are patient and/or client directed therapies and I am directing Martha Bray FNP-BC, APRN,(AHC II, Inc.) and/or her staff to perform the above procedures and that in doing so I, and any and all parties that may represent me or my estate, hold harmless AHC II, Inc., Martha Bray, the staff and all other controlling or involved entities or manufacturers.

_____ (Please Initial) **HEALTH CARE STAFF.** I am aware that among those who attend Me on My behalf 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 operation, procedures, and Treatments.

_____ (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) **GUARANTEES:** I acknowledge that my treatment with AHC II, LLC and/or Martha L. Bray, or any interested entity or party recommended by Martha Bray does not constitute a guarantee or promise of improvement or cure of my symptoms or disease. I further understand that preventative treatment does not constitute a guarantee or promise to prevent disease.

_____ (Please Initial) **INSURANCE:** I understand that AHC II, Inc. is a fee-for-service company and does not belong to a Preferred Provider Program (PPO) or a Health Maintenance Organization (HMO), and does not accept insurance. Therefore, I am responsible for all charges incurred with AHC II, Inc. Further I understand that Martha Bray does not code for nor bill insurance companies. I understand AHC II, Inc., Advanced Health Clinic, LLC, Martha Bray, and/or their representatives will not provide any information, nor provide correspondence to my Insurance Company, including billing or coding. I further understand that Martha Bray is not a Medicare or Medicaid provider

_____ (Please Initial) **PAYMENT:** I understand all fees are collected by Advanced Health Clinic, LLC, in behalf of AHC II, Inc. 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 plus an additional $25 service fee.

_____ (Please Initial) **GOVERNING LAW**: This Agreement shall be interpreted and enforced in accordance with the laws of the State of Utah. Further, you agree that this agreement shall be governed by, construed, and enforced in accordance with the laws of the State of Utah and subject to the jurisdiction of the Judicial District Court of the State of Utah in and/for Davis County.

_____ (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.

PRIVACY POLICY AND CONFIDENTIALITY: 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, LLC, AHC II, Inc., and Martha Bray transmit from a secure, encrypted network server, however, we cannot guarantee that any information you receive 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 Advanced Health Clinic, LLC AHC II, Inc., Martha Bray and/or her staff or representatives 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. You are further notified and understand that contacting us via those means, you are waiving your Privacy Rights. Advanced Health Clinic, AHC II, Inc. or Martha Bray 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. In addition, I authorize Martha L. Bray to discuss my health care information with other health care providers I may see at Advanced Health Care, LLC, and/or with Dr. Diane Farley-Jones, consulting physician (when necessary), on an as needed basis and give consent to do so to enable the best coordination of my care. I do further consent to allowing my picture to be taken and to be placed in my file for identification procedures. I further understand that my chart will always remain the property of and in the care of AHC.

_____ (Please Initial) **CONFLICT RESOLUTION:** I understand and consent that all therapies, services, procedures and/or treatments are patient and/or client directed and I have directed Martha Bray FNP-BC, APRN,AHC II, Inc., and/or her staff to perform the those therapies, services, procedures and/or treatments and that in doing so I, and any and all parties that may represent me or my estate, hold harmless AHC II, Inc., Martha Bray, the staff and all other controlling or involved entities or manufacturers. I agree to settle any claim, dispute, or disagreement I have with Martha L. Bray, AHC II, Inc., 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.

_____ (Please Initial) **MEDICAL LIABILITY INSURANCE:** We hereby inform you and by signing below, you acknowledge that you are aware that AHC II, Inc, Martha Bray, and/or her staff may not be insured by medical liability insurance. Most treatments and/or procedures that are offered are not covered by medical liability insurance.

_____ (Please Initial) **ASSUMPTION OF RISK.** You hereby acknowledge that after having read carefully and understood fully the terms of this Agreement, and that after having adequate time to ask any questions about this Agreement or the Treatments, Services, and/or the Therapies that you may have, you are willing to assume any and all risks associated with the Treatments, Services, and/or the Therapies including without limitation those described in this Agreement. You acknowledge that no explanation or description of the Treatments can ever be fully explain every possible risk, side effect, or complication that may or could arise from the Treatments, Services, and/or the Therapies but that by signing this Agreement, You nevertheless acknowledge Your willingness to assume such risks and that Your consent to the Treatment, Services, and/or Therapies is willing, voluntary, and informed.

BY SIGNING THIS FORM(S), YOU ARE FORMALLY AGREEING TO ABIDE BY THE TERMS DESCRIBED IN THIS DOCUMENT.

Therefore, I_____(please print), being of sound mind, and having read the above information, fully understand my rights and responsibilities, and do hereby consent to being a client and/or patient of AHC II, Inc. and Martha L. Bray, FNP-BC, APRN, AHN-BC, BCIM.

SIGNATURE: X_____ Date _____

Address: _____

City _____State _____ Zip Code _____

Name if other than client _____

Relationship to client _____

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]