INFORMED CONSENT
ADVANCED HEALTH CLINIC (AHC, II INC.)
& VORTEX MEDICAL SERVICES, LLC
Peggy L. Wallace, FNP-C, APRN

General Understanding:
_____ (Please Initial) I hereby acknowledge and understand that Peggy L. Wallace, is a Family Nurse Practitioner, Board Certified, (FNP-C), and Advanced Practice Registered Nurse (APRN). Peggy Wallace is an employee of AHC II, Inc., and Independent Contractor under the business of Vortex Medical Services, LLC, who leases from Advanced Health Clinic, LLC. I further understand Peggy L. Wallace is licensed by the State of Utah to practice independently as a Family Nurse Practitioner. I understand that Peggy L. Wallace, FNP-C specializes in and employs methods that may be considered to be "alternative", "holistic", "complimentary" and/or "functional" medicine. I 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, Peggy Wallace FNP-C highly recommends I consult and work with my physician and/or specialist.

You are hereby notified that Peggy L. Wallace may utilize a BioCommunication device(s) and empower you through health recommendations and options, so you may make informed decisions about your health, wellness, and lifestyle as it pertains to your health.

_____ (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., Peggy Wallace and/or her representatives may use are NOT used to diagnose, recommend 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 the opportunity to discuss them. No procedures, medications, or other health care treatments will proceed until I have, to my satisfaction, received a full explanation. I have the right to consent or refuse any proposed procedure or therapeutics 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
_____ (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 and mAH, methods involve 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 anticoagulant (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 anticoagulant (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 administered the Treatments and that I consent to said treatments every time they are administered thereafter. I further acknowledge and understand and hereby consent that any of the above

treatments may be administered by Peggy Wallace, 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 BioPhotonic Therapy (BPT) 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 of the risks, side effects, and complications stated in the paragraph above and 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 limitation all Treatments that have been addressed in this Informed Consent including but not limited to Intravenous Micronutrient Therapy, Prolotherapy, Ozone therapy and BPT, 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 as stated in the paragraph above, may consist in whole or part of experimental procedures and methods, including without limitation 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.

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 Peggy Wallace, FNP-C, 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 Peggy Wallace, 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 satisfactorily 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 me or my representative before proceeding with any treatment plan.

_____ (Please Initial) I agree to provide and will continue to provide, Peggy Wallace FNP-C 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 Peggy Wallace 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 Peggy Wallace and/or her staff updated with my current medical status before any treatment is performed. I covenant that all the information I provide Peggy Wallace 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 Peggy Wallace FNP-C, 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., Vortex Medical Services LLC, Peggy Wallace, 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 Peggy L. Wallace, or any interested entity or party recommended by Peggy Wallace 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 Peggy Wallace FNP-C, does not code for nor bill insurance companies. I understand

AHC II, Inc., Advanced Health Clinic LLC, Vortex Medical Services LLC, Peggy L. Wallace FNP-C, and/or their representatives will not provide any information, nor provide correspondence to my Insurance Company, including billing or coding. I further understand that Peggy Wallace is not a Medicare or Medicaid provider

_____ (Please Initial) **PAYMENT:** I understand all fees are collected by Advanced Health Clinic, LLC, on 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 per the laws of the State of Utah. Further, you agree that this agreement shall be governed by, construed, and enforced under the laws of the State of Utah and subject to the jurisdiction of the Judicial District Court of the State of Utah in and/or 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 to provide 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 Peggy Wallace 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 is available online or at Advanced Health Clinic, LLC (AHC). If you choose to contact Advanced Health Clinic, LLC AHC II, Inc., Peggy Wallace 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 by contacting us via those means, you are waiving your Privacy Rights. Advanced Health Clinic, AHC II, Inc. or Peggy Wallace 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 per such policies. In addition, I authorize Peggy L. Wallace FNP-C to discuss my health care information with other health care providers. 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 Peggy Wallace FNP-C, APRN, AHC II, Inc., and/or her staff to perform those therapies, services, procedures and/or treatments and that in doing so I, and all parties that may represent me or my estate, hold harmless AHC II, Inc., Vortex Medical Services LLC, Peggy Wallace, the staff and all other controlling or involved entities or manufacturers. I agree to settle any claim, dispute, or disagreement I have with Peggy Wallace, 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 a 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, Peggy Wallace, 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 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 Peggy L. Wallace, FNP-C, APRN.

SIGNATURE: X_____ Date _____

Address:
_____

City _____State _____ Zip Code _____

Name if other than client
_____

Relationship to client
_____

WITNESS: _____ Date _____

INFORMED CONSENT
ADVANCED HEALTH CLINIC (AHC, II INC.)
& VORTEX MEDICAL SERVICES, LLC
Peggy L. Wallace, FNP-C, APRN

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

This agreement is between Peggy Wallace, FNP-C, Advanced Practice Registered Nurse (APRN), ("Physician") whose principal place of business is 630 W. Shepard Lane, and patient _____ ("Patient") (name), who resides at

_____ (address) 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.

Peggy L. Wallace, FNP-C, APRN agrees to provide the following medical services to the Patient (the "Services"):

Any and all services provided by AHC II, Inc. and Peggy L. Wallace, FNP-C, APRN

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

- Patient agrees **not to submit a claim** (or to request that the Physician submit a claim) to the Medicare program for 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/her.
- 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 Peggy L. Wallace, FNP-C, APRN for AHC II, Inc.

_____ [Patient signature] _____ [Witness signature]