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 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 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."*

630 W. SHEPARD LN. • FARMINGTON, UT 84025 • 801-447-8680/FAX 801-447-4211 • 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) IF YOU DESIRE, WE WILL SEND YOU AN OCCASIONAL NEWSETTER AND A NOTICE OF UPCOMING EVENTS. IF YOU WISH TO HAVE FINANCIAL RECORDS EMAILED (RECEIPTS, ETC) PLEASE SEE PRIVACY POLICIES BELOW:

HOME PHONE:	CELL NUMBER:

OCCUPATION:	EMPLOYER:	EMPLOYER PHONE:

NAME OF PERSON WHO REFERRED YOU:

OTHER FAMILY MEMBERS SEEN HERE:	NAME/PHONE NUMBER OF PERSON/RELATIVE NOT LIVING WITH 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, 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. You may revoke this authorization by calling (800) 666-5222, ext. 2, to arrange payment for any outstanding checks and service fees due. 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 does not bill insurance nor file insurance claims.

IF YOU WILL BE SENDING IN HAIR SAMPLES, 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** _____

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:

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. 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 IS AVAILABLE ONLINE OR AT ADVANCED HEALTH CLINIC, LLC.

_____ **(Please Initial)** *I have received a copy* ***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.*

INFORMED CONSENT

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. 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 Advanced Health Clinic, LLC (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. I understand that AHC provides services for Independent Contractors and is exclusively an office-based practice. I recognize they are 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, I MAINTAIN A RELATIONSHIP WITH ONE OR MORE PHYSICIANS QUALIFED TO CARE FOR MEDICAL CONDITION(S). 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 understand that by signing this informed consent I agree to hold harmless, AHC and its employees and/or representatives from all professional and personal liability. I understand AHC is constantly improving; therefore all policies are subject to change (for the better ☺).

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.

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.

I understand that I am not required to purchase from H & N any 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 understand that supplements are not meant to replace adequate medical care.

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 recommendations made to me by practitioners are simply that, recommendations. Any purchase I make is of my own free will.

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.

Client Name (Please Print) _____ **Signature** _____ **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 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.

Client Name (Please Print) _____ **Signature** _____ **Date**_____

Parent or Guardian signature if under 18_____ Date _____

Witness _____Date _____

Loftis Manual Therapies

Client Information

Congratulations on your decision to see us!

Name_____ Date_____

Birth Date_____ Social Security #_____

Email address:_____

Address_____

Home Phone_____ Work Phone_____Cell_____
(Please circle the phone number that is best to reach you during our office hours.)

How did you discover our office?_____

Reason for consulting our office today:_____

Please list any concerns in order of importance:
1._____ 2. _____ 3._____

Have you seen any other professional for these concerns? Y N
If yes, describe the treatment and any results:
_____

Please check each of the following that has ever applied to your Health

☐ Sick a lot	☐ ADD/ ADHD	☐ School difficulties
☐ Earaches	☐ Poor balance or coordination	☐ Stress or Anxiety
☐ Sleeping difficulties	☐ Bed wetting	☐ Social fears/ problems
☐ Concussion	☐ Asthma/ Allergies	☐ Scoliosis Spinal problems
☐ X-rays or MRI	☐ Bone fracture	☐ Car accident
☐ Spinal or Head injury	☐ Falls	☐ Neurological conditions
☐ Birth Trauma (forceps, vacuum, c-section)		☐ Slow development
☐ Headaches		

If you checked any of the above boxes please explain in detail when and how the incident occurred as well as what was done about it and how it currently affects your Health.
_____
_____
_____
Has you ever been to a Chiropractor or before? Y N When_____
What were the results?_____
Why did you stop going?_____

_Please describe your:
Sleep: Excellent_____ Good: _____ Poor: _____
Exercise_____

Do you take a daily Multi-vitamin? _____
Medications? (Please explain)
_____

Is there anything else that we need to know about you that was not addressed on this form?

_____

Payment Policy

Payment is due at the time of, or previous to, services being rendered. If you have insurance you may be able to be reimbursed for part of your expenses at our office.

Informed Consent

Your examination will determine how your neuro-musculo-skeletal system is functioning. Treatment is aimed at restoring proper function to dysfunctional areas. The goal of Sports Medicine care is to treat imbalances and dysfunctions in the somatic nervous system (the part of the peripheral **nervous system** associated with the voluntary control of body movements via skeletal muscles.) By restoring proper function the body is more likely to heal itself, however exactly what benefits you will receive, no one can predict.

There are certain risks that have been reported to be associated with Sports Medicine care. Such risks include, but are not limited to increased pain post treatment, fractures, dislocation, bruising, stroke, and other neurological complications. However, these incidents are extremely rare and the clinician will use his best judgment to try to avoid any negative events. The most common adverse effect that you might experience is muscle soreness.

By my signature I acknowledge that there are risks inherent in receiving chiropractic care and I give the doctor permission to perform a complete examination and deliver treatment to me. I also acknowledge that the information I have provided is complete and accurate to the best of my ability.

_____ _____

Name Signature

_____

Date

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. Our privacy manual is available at any time for you to review. A more detailed privacy policy is available that you may take with you upon request.

Each practitioner at Advanced Health Clinic, L.L.C. is a private contractor and works separately. However, situations sometimes arise when a client may benefit from the services of more than one practitioner. In the event this is true of me, I allow other practitioners to review my file and/or discuss my health needs with me or my chiropractor.

I have had a chance to ask questions about the privacy policy and I give my permission to this office to disclose my name and, or protected health information in accordance with such policies.

Solicitation Agreement

I, _____, hereby certify that I elect to receive services from Treylan Loftis and that one or more of the following is true:

- I have never received services from Positional Release Therapy Institute, Corp. ("PRTI").
- I have received services previously from PRTI, but I was not solicited by Mr. Loftis on or after July 3, 2020, and I choose to receive services from Mr. Loftis.

_____ _____

Name Signature

_____

Date

_____ _____

Witness Signature Date