ELEVATE YOUR WELLNESS CENTER (EYWC)
1520 W Branch ST
Arroyo Grande, CA 93420
(805) 269-6655

Elevate Your Wellness Center

Name:_____ Date_____

Street Address:_____

City:_____ State:_____ Zip:_____

Phone Number: _____ Email:_____

I do hereby request membership in Elevate Your Wellness Center ("EYWC") to be treated as a patient by a Tribal Provider ("TP") licensed and approved by First Nation Medical Board ("FNMB"). With the signing of this Agreement, I/we agree that all people have a divinely-given right to choose and receive for themselves any type of healing they feel is best for their mind, body and spirit. These options include, but are not limited to, all forms of indigenous medicine (e.g., alternative, complementary, holistic, integrative, etc.) whether traditional or non-traditional, as well as conventional medicine.

In addition, I affirm and understand that: (1) EYWC members are protected by the First and Fourteenth Amendments to the U.S. Constitution as well as the United Nations General Assembly (Universal Declaration of Human Rights adopted at the Palais de Chailot in Paris on December 10, 1948); (2) THB is outside the jurisdiction and authority of federal, state, county, and city agencies and authorities for any and all complaints or grievances against FNMB, FNMB licensees, FNMB

staff, Elevate Your Wellness Center Clinics (“EYWCC”), and EYWCC staff; and (3) EYWC member records are the private property of EYWCC- licensed facilities and are kept confidential.

I also swear under penalty of perjury that I am here solely on my behalf and not as an agent or representative for any Federal, State, County, or City Agencies, that I neither represent any Board (e.g., medical, zoning, etc.) or Licensing Agency (e.g., government, healthcare, etc.) nor am I on a mission of entrapment or investigation on behalf of these or any other agencies, either on this or any subsequent visit(s), and I agree to pay $250,000.00 (Two Hundred Fifty Thousand Dollars and No Cents) in liquidated damages if I am found to be in violation of this covenant. **Initials** (___)

UNDERSTANDING

I (and my family) agree to become a patient(s) and private member(s) of EYWC so that I/we may be entitled to receive goods and services from a TP providing service in a EYWCC facility. I/We further understand that it is entirely my/our own responsibility to consider the advice and recommendations offered to me/us by TPs or our fellow EYWC members and to educate myself/ourselves as to the possible risks and benefits of such recommendations. I/We agree to hold the tribal practitioners, healers, technicians, staff, and other EYWC members harmless from unintentional liability resulting from my/our indigenous healthcare, except for harm that results from criminal misconduct or gross negligence as determined by FNMB and/or defined by Crow Tribal Court. I/We hereby submit myself/ourselves to the jurisdiction of FNMB for the referral of any and all professional complaints against TPs and to submit such complaints to FNMB for dispute resolution. Further, I/We agree to submit any civil complaints against TPs to Crow Tribal Court for dispute resolution. **Initials** (_____)

NOTICE

Notice is hereby given to all persons that they may be in violation of Civil and Constitutional Rights should they receive a copy of this Agreement and then act under the color of law to intentionally interfere with the free exercise of the Rights retained by THB members under the Ninth Amendment (see Title 42, U.S.C 1983 et seq.; see also Title 18, Sec 241-42).

ANNUAL FEES

$35.00 (Member) $15.00 (Additional fee for Spouse) Free (Children <18 y/o at home)

I enclose the fees required as consideration for my/our membership affiliation and agreement. I agree to pay these fees yearly, unless otherwise instructed. The term of my/our membership begins with the date of the signing of this agreement. I hereby certify, attest and warrant that I have carefully read the above and foregoing EYWC membership agreement and I (and my family) fully understand and agree with its terms and conditions.

Member Signature:_____ Date:_____

Spouse Signature:_____ Date:_____

CHILDREN

(name, age, gender)

1._____ 2._____

3._____ 4._____

First Nation Medical Board (“FNMB”) d/b/a Elevate Your Wellness Center is authorized by agreement with Crow Nation to create a Tribal Health Care Program that licenses Tribal Providers of indigenous medicine to provide indigenous healthcare services for its private EYWC members. Tribal Providers include allopaths (MDs), osteopaths (DOs), chiropractors (DCs), naturopaths (NDs), homeopaths (HMDs), and other healing arts (i.e., nurses, massage therapists, colon therapists, etc.). Private membership includes indigenous medicine patients, members of the Crow Nation, and Crow Nation affiliates.