Elevate Your Wellness Center
1520 W Branch ST
Arroyo Grande, CA 93420
(805) 269-6655

Elevate Your Wellness Center

Patient Consent

Patient Name:_____ DOB:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Number:_____ Email:_____

Patient Consent for Medical Treatment

General: I understand that Elevate Your Wellness Center (“EYWC”) specializes in indigenous medicine and this practice may be referred to as “unconventional,” “unorthodox”, “alternative”, “complementary”, “holistic”, and/or “integrative” medicine. Consent: I understand that, absent emergency or extraordinary circumstances, no substantial procedures are performed upon me unless and until I have had an opportunity to discuss them with the physician or other health professional to my satisfaction and that I have the right to consent, or refuse to consent to any proposed procedure or therapeutic course. Diagnostics: I understand my Tribal Provider (“TP”) may order tests deemed necessary to assess/monitor my health. Treatments: I understand that a TP may prescribe, but is not limited to, homeopathics, vitamins, minerals, amino acids, herbs,

injections (e.g., intravenous, subcutaneous intramuscular) and/or other innovative approaches for my health. Research: I hereby agree to allowing my clinical data and lab reports be used for research and scientific purposes, to aid in the advancement of medical knowledge, provided my identity is kept confidential.

Guarantees: I acknowledge that my treatment with EYWC does not constitute a guarantee or promise of cure.

Risks: I am aware the practice of medicine is not an exact science and my diagnosis/treatment may involve risk of injury. Insurance: I understand that EYWC and its TPs operate as a fee-for-service operation, does not participate in Medicare, a Preferred Provider Program, or Health Maintenance Organization and that EYWC does not accept insurance.

Membership: I understand there is an annual individual membership fee of $35 (THRITY-FIVE DOLLARS AND NO CENTS) OR annual family membership fee of $50 (FIFTY DOLLARS AND NO CENTS) in order to be seen in EYWC.

Payment: I understand that payment is due at the end of each visit. In the event of a returned check, I will reimburse EYWC, by credit card or cash, for the total of the check and a $30 (THIRTY DOLLARS AND NO CENTS) service fee. Any special payment options must be arranged with EYWC and/or its CTPs prior to treatment.

Products: I understand that items that are purchased and removed from EYWC premises are NOT returnable. Jurisdiction: Agreement shall be interpreted and enforced in accordance with tribal laws of the Crow Nation. Severability: If any term, provision or condition of this Agreement, or any application thereof, should be held by the Crow Tribal Court 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.

Indemnification: I agree to hold EYWC and its TPs harmless against any and all liability, claims, suits, losses, costs, and legal fees caused by, arising out of, or resulting from any negligent act or omission that may occur in the performance and/or failure to perform medical duties that occur in good faith without malicious intent. These indemnification obligations shall continue in full force and effect notwithstanding the termination of treatment by EYWC and its TPs.

Complaints: I agree to file any complaints against a TP with the First Nation Medical Board ("FNMB").

Arbitration: The parties agree that any civil claim or dispute arising under or out of this Agreement shall be subject to binding arbitration pursuant to the tribal laws of the Crow Nation and FNMB rules and regulations. There shall be a single arbitrator agreed upon and selected by the parties. In no event shall either party be entitled to punitive damages. Declaration: I swear, under penalty of perjury, that I am presenting myself to be seen by a TP with EYWC as a patient with a legitimate health concern who is requesting medical attention and/or intervention and that I am not here impersonating another individual, using false identification, or under false pretenses for which I will be subject to all penalties under state, federal, and/or tribal if I am found guilty of any such crimes.

Agreement: This agreement is binding upon any and all of my heirs, assigns, family members, next of kin, legal representatives, legates, and distributes and it applies to all present and future services on behalf of the above-named persons and entities, their staff or assistants, and may not be altered or amended except by written agreement. Therefore, being of sound mind, and having read the above information, I fully understand my rights and responsibilities and hereby consent to becoming a member of EYWC and being evaluated and treated as a patient by its TPs for medical care.

_____ _____

Signature Date

_____ _____

Signature Date