New Patient Application

Patient Information

Name: (Last, First, MI)			Today's Date:
Address:	City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:	
SSN/DL # or other ID:	DOB:	Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Other ☐ Divorced ☐ Widowed ☐ Separated
Race:	Ethnicity:	Preferred Language:	Email:

Financial Responsible Party

Is the patient the responsible party/guarantor? ☐ Yes ☐	Relationship to Patient: ☐ Self ☐ Parent ☐ Other	
Name:	Address:	
Occupation:	Employer:	Email:
Home Phone:	Work Phone:	Cell Phone:

Emergency Contact

Name:	Address:	
Home Phone:	Work Phone:	Cell Phone:
Relationship to Patient:		

Referral Info

How did you find us? ☐ Internet ☐ Radio ☐ Family/Friend (please list name) ☐ Other

_____

Is there anyone you can think of that may benefit from our services?

Name: _____ email _____ Phone _____

Name: _____ email _____ Phone _____

Primary Care Provider

Please list your Primary Care Provider

Name: _____ email _____ Phone _____

Please maintain your Primary Care Provider throughout your care at Denali Medical. Denali Medical will not be assuming your primary care as part of your treatment therapy. We will answer any and all questions you have about your therapy to the best of our ability.

By Signing below, I acknowledge that the information provided is correct to the best of my ability.

Patient Signature: _____ Date: _____/_____/_____

Guardian Signature: _____ Date: _____/_____/_____

Guarantor Signature: _____ Date: _____/_____/_____

HIPAA Privacy Notice

This notice describes how medical information about you may be used and shared and how you can get access to this information. Please review it carefully.

Uses and Disclosures of Your Medical Information

1. Treatment. Your "Protected Health Information" is routinely shared among health care professionals involved in your care to coordinate or manage treatment, both within and outside Denali Performance Clinic Services and collaborating clinics. History and Examination findings, X-ray results, Laboratory results, etc., may be shared with collaborating providers as part of your treatment.
2. Payment. Your medical information may be shared with your medical insurer so that Denali Performance Clinic Services can be paid by your insurer for services provided to you. A summary of your treatment may be provided to your insurer.
3. Health Care Operations. Your medical information is sometimes used to assess and improve quality of care or reallocate resources. Non-patient-specific information is used wherever possible. The details of your procedure, for instance, may be shared among providers at a department meeting to evaluate your procedure based on the outcome.
4. Facility Directory. Unless you tell us not to, we may use the following information in a facility directory: (a) your name; (b) your location in Denali Performance Clinic Services; (c) your general condition; and (d) your religious affiliation. We may share this information (except for your religious affiliation) with members of the clergy or other persons who ask for you by name. You may limit or prohibit these uses and disclosures by notifying a Denali Performance Clinic Services representative, doctor or nurse orally or in writing of your restriction or prohibition. In an emergency or if you cannot tell us what you want us to do, we will do what we think you would want us to do, based on your other visits to Denali Performance Clinic Services and it's collaborating clinics (if any). We will tell you about any uses or disclosures as soon as we can and give you a chance to object as soon as practicable.
5. State Law. State law mandates sharing of your medical information with state agencies under certain circumstances, without your consent. Examples include abuse reporting to the Department of Social Services and death reports to the Office of the Medical Examiner.
6. Medical Research. Your medical information may be used to further medical research, but only after approval by the Institutional Review Board, when written permission is not required by federal or state law.
7. Other Uses and Disclosures. Any other sharing of your medical information will be made only with your written permission, and you may take back your permission at any time so long as you tell us in writing. Exceptions include if Denali Performance Clinic Services or collaborating clinic has acted in reliance upon your permission or if your permission was obtained so that the services provided would be covered by insurance.

In addition, Denali Performance Clinic Services may contact you to remind you about your appointment or tell you about health-related benefits or services that may be of interest to you. We may use certain information (name, address, telephone number, email, dates of service, age and gender) to contact you in the future about special offers and opportunities.

Your Rights

1. You may ask us to limit our sharing of your information, but under Federal Law Denali Performance Clinic Services and collaborating clinics do not have to agree to what you ask.
2. You have the right to receive confidential communications of your information at alternative locations or by alternative means.
3. You have the right to see and get a copy of your medical records.
4. If you think there is something wrong or missing in your medical information, you can ask that it be changed, unless the information was created elsewhere, is unavailable or is determined to be already accurate and complete. This will be done under collaboration with the provider, and will requisitely be within legal parameters, and maintain provider's right to diagnose, prescribe, and treat.
5. You have a right to ask us for a limited accounting of disclosures of your information. The medical records department can provide you with more details.

The Duties of Denali Performance Clinic Services

1. Denali Performance Clinic Services is required by law to keep your medical information private and to give patients this notice of its legal duties and privacy practices for medical information. Denali Performance Clinic Services is required to agree to the terms of this notice. Denali Performance Clinic Services reserves the right to change the terms of this notice and to make the new terms apply to all medical information it keeps. This notice and any changed notices will be conspicuously posted in public spaces at the Clinic, made available on the Denali Performance Clinic Services Web site (www.denalimedicalonline.com) and given to you in paper copy upon your request.
2. Any patient believing that his or her privacy rights have been violated may complain through the Denali Performance Clinic Services Customer Relationship Management Department at 801-675-0987 or file a complaint directly with the Secretary for the United States Department of Health and Human Services. Visit www.hhs.gov/ocr/privacy/hipaa/complaints to learn more. Patients will not be retaliated against for filing a complaint.

By signing below, I acknowledge that I have read through the above information, and confirm understanding and compliance.

Patient Signature: _____ Date: _____/_____/_____

Guardian Signature: _____ Date: _____/_____/_____

Guarantor Signature: _____ Date: _____/_____/_____

Informed Consent | (Please initial each line)+

Patient Conditions of Treatment and Informed Consent to Treat

This document is a binding agreement (the "Agreement") between Denali Performance Clinic Services/Denali Performance Clinic and/or (We" "Us") and the individual patient whose name and signature appears below ("You" "Your"). In consideration of the health care services provided to You by Us at the present and at all times in the future, You agree as follows (Your agreement indicated by placing Your initials on the lines following each section and by signing in the space provided):

Initial

___ 1. **Consent for Treatment.** You hereby consent to and authorize Us to provide You with health care treatment, including without limitation medical, diagnostic, Phlebotomy, NeuroMuscular Optimization, Frequency Specific NeuroElectrical Stimulation, Pulsed ElectroMagnetic Field treatment, Laser Treatment, Instrument assisted soft tissue nasal treatment, nutritional treatment, Intravenous Micronutrient Therapy, Prolotherapy, RenuO2 and PRP O2 (together the "Treatments") administered by Us, our physicians, assistants, consultants and staff. You understand that the practice of healthcare is not an exact science and that diagnosis and treatment may involve risk of injury or death. You acknowledge that We have not made any guarantees or promises as to the outcome or the safety and efficacy of the Treatment.

___ 2. **Risks, Side Effects, Complications.** Although rare, and considered low risk we hereby inform You that there are certain unavoidable risks and potential side effects and complications to the Treatments, including without limitation infection; 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 scaring at injection sites (all of which except the leaking 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.

___ 3. **Description of Treatments.** Treatment may consist of appropriately applied neuroelectric electrodes, injections using needles, IV catheter insertion and nutrition infusion, pressure points with the intent of muscle activation. You acknowledge that the Treatments may involve insertion of needles into Your skin and veins and 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, and ozone therapy and local subcutaneous anesthetic infiltration. The exact solution and site of injection for Your Treatment, as well as the recommended sequence of Treatments, will be explained to You when We administer the Treatments.

___ 4. **Experimental Nature of Treatment.** You acknowledge and agree that the evaluation, diagnosis and treatments may consist in whole or part of what the FDA may consider experimental procedures and methods, including without limit Intravenous Micronutrient Therapy, Prolotherapy and Mesotherapy, 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. You 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 have informed You that the Treatments MAY alter, address or decrease Your pain, symptoms or complaints, but also may have no effect.

___ 5. **Healthcare Staff.** You are aware that among those who attend You on Our behalf are medical, nursing, and other healthcare personnel in training, who unless requested otherwise, may participate in patient care as part of their education. You 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, procedure and Treatments.

___ 6. **Alternatives.** You understand and have been informed that there are alternatives to the Treatments including surgery, other types of injections, prescription medications, massage, stretching and taking no action.

___ 7. **Information You Provide Us.** You have provided Us with a Complete list of all prescription and non-prescription medications and dietary supplements You are currently taking, and You agree to update Us periodically should this list change. You have provided Us with a complete list of all known allergies You may have, and all allergic or adverse reactions You have had in the past to any medicines, dietary supplements or medical treatments of any kind. You confirm that all the information You provide Us during the course of Treatments, including the information required by this Section 6, is true, accurate, complete and up-to-date to the best of Your knowledge. Your e-mail has been provided for the purpose of schedule reminders and clinic updates. Please check here to opt-out. □

___ 8. **Assumption of Risk.** You hereby acknowledge that after having read carefully and understood fully the terms of this Agreement, and after having adequate time to ask any questions about this Agreement or the Treatments that You have, You are willing to assume any and all risks associated with the Treatments, including without limitation to those described in this Agreement. You acknowledge that no explanation or description of the Treatments can ever fully explain every possible risk, side effect or complication that may or could arise from the Treatments, but that by signing this Agreement, You nevertheless acknowledge Your willingness to assume such risks and that Your consent to the Treatments is willing, voluntary and informed.

___ 9. **Miscellaneous.** You agree that this Agreement constitutes the entire agreement between You and Us regarding the subject matter hereof. No promise, representation, guarantee or warranty not included in this Agreement has been or is being relied upon by you. This Agreement shall be binding on You and Your successors, heirs, legal representatives and assigns. In case any one of the provisions of this Agreement is held invalid or illegal, such provision shall be curtailed, limited or severed only to the extent necessary to remove such illegality or invalidity. This Agreement shall be governed by the laws of the state of Utah without regard to any choice of law principal.

___ 10. **Financial Agreement.** You have reviewed, initialed and signed the financial agreement for Denali Performance Clinic.

By signing below, I acknowledge that I have read through the above information, and confirm understanding and compliance.

Patient Signature: _____ Date: _____/_____/_____

Guardian Signature: _____ Date: _____/_____/_____

Guarantor Signature: _____ Date: _____/_____/_____

Financial Policy and Agreement Form

Denali Medical Center is dedicated to professionalism and caring for our patients. We hope to be as up front and consistent as possible in explaining your obligations in our partnership to your health.

Please read, initial each blank and sign where indicated – this document describes your financial responsibilities. This is a legally binding contract between Denali Medical Center and the patient.

Initial

_____ I agree to be financially responsible for payment of all services I receive at Denali Medical Center. Cash, checks, health savings accounts, credit cards or financing are acceptable forms of payment for the service provided.

_____ I understand that the services provided at Denali Medical Center are ***not recognized or covered*** by most insurance companies and will not be billed through insurance.

_____ I understand that that Denali Medical Center's package opportunities (such as RenuO2 Regeneration Package) has a limited time span available to use the treatments. This is intended to benefit the patient, since those who have followed the treatment schedules have experienced the highest success rates.

_____ I understand that the package pricing offered at Denali Medical Center applies discounted rates. Any credits or refunds will be calculated from full valued price.

_____ I have provided Denali Medical Center my current address and other contact information. I understand that if I fail to pay the balance on my account, this may result in Denali Medical Center pursuing any collection means possible.

_____ If my account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, I will be responsible for all costs of collection, including but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency costs.

_____ I understand Denali Medical Center's financial policies and I accept responsibility for the payment of any fees associated with my care.

_____ I understand that I will be responsible for any missed appointments or any canceled appointments in which a 24 hour notice was not given. There will be a fee of $50.00 for any missed office procedures.

_____ I understand there will be a $25.00 fee for all returned checks.

_____ _____

Patient Signature Date

_____ _____

Responsible Financial Party Signature (If patient is under the age of 18) Date

Denali Medical Medicare Agreement (Only needed if you are a Medicare Recipient)

This agreement is between Denali Medical Services and patient _____ ("Patient"), who is a Medicare Part B beneficiary seeking services covered and/or not covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. This agreement serves as notice that the Physician has informed Patient that Provider has opted out of the Medicare program effective on 11/23/15 for services rendered at Denali Medical, Denali Performance Clinic, Denali Drip Room, 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.

Provider agrees to provide the following medical services as needed to Patient (the "Services"):

RenuO2 Injections, PRP Injections, IV Nutritionals, Supplementation

In exchange for the Services, the Patient agrees to make payments to Provider and/or Denali Medical Services pursuant to the Prescribed Fee Schedule. Patient also agrees, understands and expressly acknowledges the following:

- Patient agrees not to submit a claim (or to request that Provider 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 Providers 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 Providers 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 Provider 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 Provider 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 Provider for any costs and attorneys' fees that result from violation of this Agreement by Patient or his beneficiaries.

Executed on _____/_____/_____ [date] by

_____ [Patient name] _____ [Patient signature]

_____[Provider name] _____ [Provider signature]

Medications – Include Prescription and Over the Counter

Medication Name	Dose	Frequency	Date Started	Comment/Reason

*If you need additional room, please continue on another sheet of paper – maintain the same format

Nutritional Supplements

Supplement Name	Dose	Frequency	Date Started	Comment/Reason

*If you need additional room, please continue on another sheet of paper – maintain the same format

Allergies

Allergic to (List Medication or Supplement	Reaction	Date Started	Comment/Reason

*If you need additional room, please continue on another sheet of paper – maintain the same format

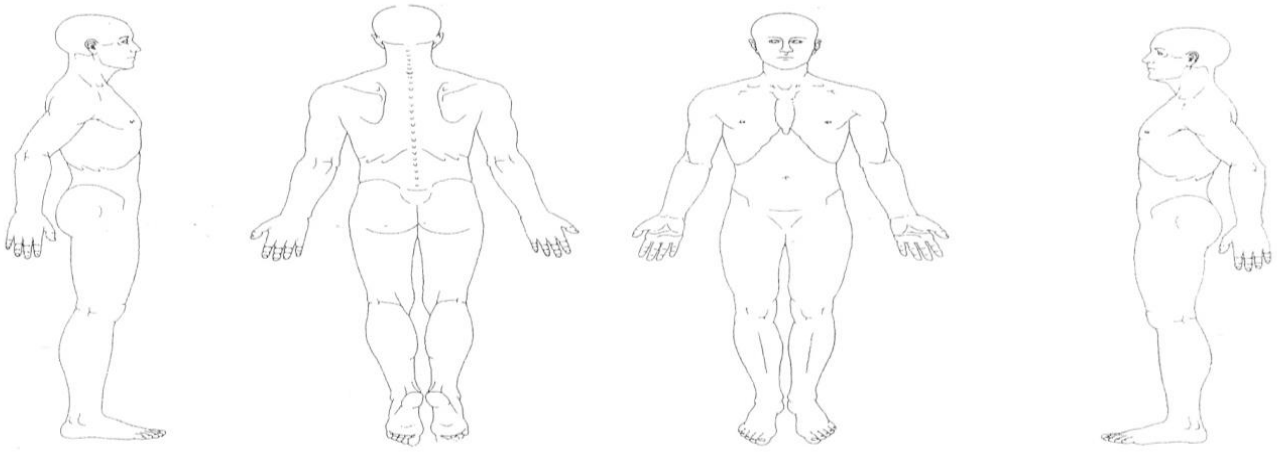
PAIN ASSESSMENT

Are you currently in pain? Yes ___ No____

Problem	Injury or trigger for issue	Onset Date	Frequency i.e. Every day	Previous Treatment or Therapy	Outcome

Use the letters provided to mark your area(s) of pain on the illustration.

A = ache **B**= burning **N**=numbness **S**= stiffness **T**=tingling **Z**=sharp/shooting



Right Side Back Front Left side

Now indicate the amount of pain you have for each area: 0 being no pain, and 10 being maximum pain

Example:____**Neck**_____

0 1 2 (3) 4 5 6 7 8 9 10

Area 1._____
1 2 3 4 5 6 7 8 9 10

Area 2._____
1 2 3 4 5 6 7 8 9 10

Area 3._____
1 2 3 4 5 6 7 8 9 10

Area 4._____
1 2 3 4 5 6 7 8 9 10

Area 5._____
1 2 3 4 5 6 7 8 9 10

Area 6._____
1 2 3 4 5 6 7 8 9 10

When was the last time that you felt well?_____

What seems to trigger your symptoms?_____

What seems to worsen your symptoms?_____

What seems to make you feel better?_____

PAST MEDICAL AND SURGICAL HISTORY

If you mark yes on any of the following, please comment specifics in the note section below

Illness	When/Onset	Y	N
Anemia		☐	☐
Arthritis		☐	☐
Asthma		☐	☐
Bronchitis		☐	☐
Cancer		☐	☐
Chicken Pox		☐	☐
Chronic Fatigue Syndrome		☐	☐
Crohn's Disease or Ulcerative Colitis		☐	☐
Diabetes		☐	☐
Emphysema		☐	☐
Epilepsy, convulsions, or seizures		☐	☐
Gallstones		☐	☐
German Measles		☐	☐
Gout		☐	☐
Heart Attack, Angina		☐	☐
Heart Failure		☐	☐
Hepatitis		☐	☐
Herpes Lesions/Shingles		☐	☐
High blood fats (cholesterol, triglycerides)		☐	☐
High blood pressure (hypertension)		☐	☐
Irritable bowel (or chronic diarrhea)		☐	☐
Kidney stones		☐	☐
Measles		☐	☐
Mononucleosis		☐	☐
Mumps		☐	☐
Pneumonia		☐	☐
Rheumatic Fever		☐	☐
Sinusitis		☐	☐
Sleep Apnea		☐	☐
Stroke		☐	☐
Thyroid disease		☐	☐
Whooping Cough		☐	☐
Other (describe)		☐	☐
Other (describe)		☐	☐

Injury	When/Onset	Y	N
Back injury		☐	☐
Broken bones or fractures (describe)		☐	☐
Head injury		☐	☐
Neck injury		☐	☐
Other (describe)		☐	☐
Other (describe)		☐	☐
Diagnostic Studies			
Bone Density Test		☐	☐
Bone Scan		☐	☐
Carotid Artery Ultrasound		☐	☐
CAT Scan (Please indicate type)		☐	☐
Colonoscopy		☐	☐
EKG		☐	☐
Liver Scan		☐	☐
Mammogram		☐	☐
Neck X-Ray		☐	☐
MRI		☐	☐
X-Ray (Please indicate type)		☐	☐
Other (describe)		☐	☐
Other (describe)		☐	☐
Surgeries			
Appendectomy		☐	☐
Dental Surgery		☐	☐
Gall Bladder		☐	☐
Hernia		☐	☐
Hysterectomy		☐	☐
Tonsillectomy		☐	☐
Tubes in Ears		☐	☐
Other (describe)		☐	☐
Other (describe)		☐	☐

Hospitalizations	Reason	When

Notes/Comments: _____

READINESS ASSESSMENT

Rate on a scale of: 5 (very willing) to 1 (not willing).

In order to improve your health, how willing are you to:

Significantly modify your diet	5 ____ 4 ____ 3 ____ 2 ____ 1 ____
Take nutritional supplements each day	5 ____ 4 ____ 3 ____ 2 ____ 1 ____
Keep a record of everything you eat each day	5 ____ 4 ____ 3 ____ 2 ____ 1 ____
Modify your lifestyle (work demands, sleep habits)	5 ____ 4 ____ 3 ____ 2 ____ 1 ____
Practice relaxation techniques	5 ____ 4 ____ 3 ____ 2 ____ 1 ____
Engage in regular exercise	5 ____ 4 ____ 3 ____ 2 ____ 1 ____
Have periodic lab tests to assess progress	5 ____ 4 ____ 3 ____ 2 ____ 1 ____
Correct and change posture	5 ____ 4 ____ 3 ____ 2 ____ 1 ____

Comments _____
_____
_____

INSURANCE DISCLAIMER

Some people ask why there is limited insurance coverage as payment. Fair question. Here's the answer straight from the government... Medicare Guidelines, Section 2251.3:

"**A treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition is deemed NOT medically necessary**"... This means that third party payers (Blue Cross, Blue Shield, Aetna, and United Healthcare) also have government permission to deny health insurance claims.

The medical approaches we take in addressing issues related to your condition are not covered by Medicare and Medicaid, and most insurance plans we've worked with in the past have also turned down claims for some of the procedures we do in this clinic. Insurance companies can be very restrictive in the types of options you might have available.