Please fax to 866.503.4341 or email to: info@sedonawellnessretreat.com

Medical History Questionnaire (Patient To Fill Out - And Return)

Name:_____ Current Date:_____

Address:_____ Home Phone:_____

City:_____State:_____Zip Code:_____Work Phone:_____

Country:_____ Birth Date:_____

Employer:_____Occupation:_____Age:_____Married or Single

Email Address:_____

Emergency Contact Person:_____Phone#_____

Please indicate the diagnosis for which you wish to use our program:_____

Date diagnosed:_____

If it is a cancer diagnosis please complete the Medical History Related to Cancer Diagnosis.
Other health concerns. Please list in order of significance.

1_____ Treatment taken/date _____

2_____ Treatment taken/date _____

3_____ Treatment taken/date _____

4_____ Treatment taken/date _____

5_____ Treatment taken/date _____

Your Health History

Health as a child was: ☐ Good ☐ Fair ☐ Poor

Childhood Illnesses: ☐ Scarlet Fever ☐ German Measles ☐ Measles ☐ Pertussis
☐ Mumps ☐ Rheumatic Fever ☐ Chicken Pox ☐ Diphtheria

Other Illnesses (Past or Present):
☐ Tuberculosis ☐ Asthma ☐ Osteoarthritis ☐ Rheumatoid Arthritis
☐ Pneumonia ☐ Typhoid ☐ Tonsillitis ☐ Gonorrhea ☐ Hypertension ☐ Herpes
☐ Epilepsy ☐ Diabetes ☐ Hay fever ☐ Alcoholism ☐ Heart Disease ☐ Hepatitis
☐ Mononucleosis ☐ Kidney disease ☐ Stroke ☐ Glaucoma ☐ SLE (Lupus)
☐ Thyroid disorder ☐ Infertility ☐ Lyme disease ☐ Depression ☐ Others:_____

Hospitalizations (year and reason):_____

Surgeries (year and type):_____

Significant falls or injuries:_____

Serious Illnesses (year and cause):_____

Vaccinations:(year, type, adverse reactions)_____

Date of last medical exam_____ Where?_____

Date of last blood test Where?_____

Other recent tests_____Where? and When?_____

Present State Of Health: Please circle which category and letter your present health is in.

1. Able to carry on normal activity to work. No special care is needed.
   - A. 100% Normal; no complaints no evidence of disease.
   - B. 90% Able to carry on normal activity; minor signs of symptoms of disease.
   - C. 80% Normal activity with effort; some sign or symptoms of disease.

2. Unable to work. Able to live at home, and care for most personal needs. A varying amount of assistance needed.
   - A. 70% Cares for self. Unable to carry on normal activity or do active work.
   - B. 60% Requires considerable assistance, but is able to care for most of oneself.
   - C. 50% Requires considerable assistance and frequent medical care

3. Unable to care for self. Requires equivalent of institutional or hospital care. Disease may be progressing rapidly.
   - A. 40% Disabled; requires special care and assistance
   - B. 30% Severely disabled; hospitalization is indicated although death not.
   - C. 20% Very sick; hospitalization necessary; active supportive treatment needed.
   - D. 10% Moribund; fatal precesses progressing rapidly.

Family Current State Of Health (Age & Health State/Condition)

Mother:_____

Father:_____

Siblings:_____

Spouse/Partner:_____

Children:_____

Please Check Family History Conditions:

☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ Stroke ☐ Epilepsy
☐ Asthma ☐ Mental Illness ☐ Hay-fever ☐ Alcoholism ☐ Glaucoma ☐ Hives
☐ Kidney Disease ☐ Physical or Emotional Abuse ☐ Tuberculosis ☐ Others:_____

Medical History Related to Cancer Diagnosis

Record baseline on cancer:Type of cancer:_____Primary site:_____

Stage:_____Grade (if known):_____Date of initial diagnosis:_____

Were any of the following used in diagnosis? (Attach copy of written interpretations)
☐MRI ☐CAT scan ☐Ultrasound ☐PET scan ☐X-Rays ☐Other:

Describe any metastasis: _____
_____

Indicate treatment, how many times, date, and description.

Type	Number of Times	Date(s)	Description
Surgery			
Chemotherapy			
Radiation			
Hormone Therapy			
Other			

Was there a recurrence after initial treatment? ☐No ☐Yes, If so, please describe:

Describe current treatments and current status:

Please Indicate as Appropriate – either Yes, No, or in the Past (Hx or history of)

Eyes
Wear glasses/contacts Y N Hx
Eye disease or injury Y N Hx
Blurred or double vision Y N Hx
Halos or Sparks Y N Hx
Glaucoma Y N Hx

Ear/Nose/Throat/Mouth
Hearing loss or ringing Y N Hx
Earaches or drainage Y N Hx
Sinus pain or Runny nose Y N Hx
Nose bleeds Y N Hx
Mouth sores Y N Hx
Bleeding gums Y N Hx
Bad Breath Y N Hx
Dental Problems Y N Hx
Sore throat/voice change Y N Hx
Swollen glands Y N Hx

Cardiovascular & Lungs
Stroke Y N Hx
Heart trouble Y N Hx
Blood pressure (BP) _____/_____
Chest pain/angina Y N Hx
Palpitations (flutters) Y N Hx
Wheezing Y N Hx
Shortness of breath Y N Hx
Walking or Laying Down?
Swelling of extremities Y N Hx
Feet &/or Ankles &/or Hands?
Frequent cough Y N Hx
Cough with blood Y N Hx
Last chest x-ray Y N Hx
Bronchitis/Pneumonia Y N Hx
Asthma Y N Hx
Mitral Valve Prolapse Y N Hx
Rheumatic Fever Y N Hx

Blood & Lymphatic
Cuts are slow to heal Y N Hx
Tendency Bleeding/bruise Y N Hx
Anemia Y N Hx
Phlebitis or Blood clots Y N Hx
Inflammation vein Y N Hx
Past transfusion Y N Hx
Enlarged glands Y N Hx

Skin
Rash or itching Y N Hx
Change in skin color Y N Hx
Dry skin Y N Hx
Change in hair/nails Y N Hx
Concern/change in mole Y N Hx

Genitourinary
Frequent urination Y N Hx
Burn/painful urination Y N Hx
Blood in urine Y N Hx
Change in force/stream Y N Hx
Incontinence/Dribbling Y N Hx
Kidney Stones Y N Hx
Urinary Tract Infections Y N Hx
Sexual Difficulty Y N Hx
Sexually Active Y N Hx
Birth Control Method?
_____
STDs? Y N Hx
_____
Male - Testicle pain Y N Hx
Female - Length of cycle _____
Female - Irregular periods Y N Hx
Female - Pain w/periods Y N Hx
Female - Hx abnormal pap Y N Hx
Female - Vaginal Discharge Y N Hx
Female - Date of Last PAP _____
Female - # or live births _____
Female - # of pregnancies _____
Female - Pregnancy related problems?
_____

Breast
Breast changes/lumps Y N Hx
Breast discharge Y N Hx
Breast pain Y N Hx

Musculoskeletal
Joint pain Y N Hx
Joint stiffness/swell Y N Hx
Weakness of muscle/joint Y N Hx
Muscle pain or cramps Y N Hx
Back pain Y N Hx
Cold extremities Y N Hx
Difficulty in walking Y N Hx
Varicose veins Y N Hx
Hernia Y N Hx

Immune
Catch every cold/flu? Y N Hx
Difficulty clearing cold? Y N Hx
Cancer Y N Hx
Type: _____
Herpes Simplex Virus Y N Hx
Chicken Pox Virus Y N Hx
Hepatitis A, B or C No
Other Infectious Diseases:

Neurological
Lightheaded/dizzy Y N Hx
Freq. /recurring headaches Y N Hx
Tremors(shaking) Y N Hx
Numbness or tingling Y N Hx
Head injury Y N Hx
Convulsion/Seizure Y N Hx
Paralysis Y N Hx
Memory loss Y N Hx
Nervousness/anxiety Y N Hx
Depression Y N Hx
Insomnia Y N Hx

Endocrine
Glandular/hormone issue Y N Hx
Excessive Thirst/urination Y N Hx
Heat/Cold Intolerance Y N Hx
Change in hat/glove size Y N Hx
Recent weight change Y N Hx
Skin becoming dryer Y N Hx
Hair loss Y N Hx
Diabetes Y N Hx
Thyroid Disease Y N Hx

Gastrointestinal
Loss of appetite Y N Hx
Change in bowl movement Y N Hx
Nausea or vomiting Y N Hx
Frequent diarrhea Y N Hx
Painful bowel movements Y N Hx
Constipation Y N Hx
Abdominal pain Y N Hx
Rectal bleeding Y N Hx
Blood in stool Y N Hx
Liver/Gallbladder disease Y N Hx
Ulcers Y N Hx
Hemorrhoids Y N Hx

Allergies
Penicillin or antibiotics Y N Hx
Stinging insects Y N Hx
Aspirin Y N Hx
Morphine or Demerol Y N Hx
Novocain or anesthetics Y N Hx
Antitoxins (i.e. - Tetanus) Y N Hx
LIST KNOWN ALLERGIES

Exercise? How many times per week? _____ Length of Time per workout? _____
take Aspirin? How many pills per week? _____ Milligrams per pill? _____ Stomach Upset? Y N
use Caffeine? Soda _____ Tea _____ Coffee _____ Chocolate _____ Other _____
use Tobacco? Never ____ Packs per day _____ Previous, but quit. When? _____
use Alcohol? Never ____ Rarely___ Moderate_____ Daily_____ When did you quit? _____
Recreational Drugs? Never ____ Rarely___ Past ____ Recently ____

1. What is your current weight? _____ What is the weight that you feel your best? _____
2. How do you feel on waking in the morning? _____
3. Are you willing to make diet and lifestyle changes in order to achieve optimum health? _____

Prescription Medications: Include dosage and how long taken. (attach sheet if needed)

Non-prescription: Herbs and vitamins. (attach sheet if needed)

Allergies: list any allergies or adverse reactions to inhalants, foods, medicines, perfumes, perfumes, smoke, chemicals, etc.

Have you had an occupational or environmental exposure to noxious or hazardous substances?
☐ No ☐ Yes- Explain:

Have you ever been exposed to any of the following?

1. Agricultural chemicals (pesticides, insecticides)? ☐ No ☐ Yes
2. Industrial/workplace chemicals? ☐ No ☐ Yes
3. Cigarette smoking? ☐ No ☐ Yes How much? How long?
4. Second hand smoke? ☐ No ☐ Yes How much? How long?
5. Alcohol use? ☐ No ☐ Yes How much? How long?
6. Recreational drugs? ☐ No ☐ Yes How much? How long?
7. Electromagnetic fields? ☐ No ☐ Yes
8. Other? ☐ No ☐ Yes Explain

Habits:

Do you use coffee? ☐ Yes, currently ☐ Yes, in past ☐ No ☐ Caffeine ☐ Decaffeinated
How many cups per day?

Alcoholic beverages? ☐ Yes, currently ☐ Yes, in past ☐ No What kind?
How many per day/week?

Tobacco: Do you smoke/chew? ☐ Yes, currently ☐ Yes, in past ☐ No How many years?
How much? How often?

Recreational Drug Use? ☐ Yes, currently ☐ Yes, in past ☐ No Explain:

General:

Do you sleep well? ☐ Yes ☐ No Average Hours per night Do you wake rested? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No What type? How often?

How would you describe your sense of well-being?

What is your stamina or general energy level like?

Food Issues/Sensitivities:

Do you have any food allergies? ☐ Yes ☐ No If yes, please list:

Do any foods give you significant gas, pain, or bloating? ☐ Yes ☐ No If yes, please list:

Gastrointestinal:

Does food generally sit well in your stomach and digest without difficulty? ☐ Yes ☐ No

Are your bowel movements generally formed or loose? Color?

How often do you have a bowel movement? (3 per day or week)

Do you have gas or abdominal bloating ☐ Yes ☐ No

Do you need to strain to have a bowel movement? ☐ Yes ☐ No

Do you have hemorrhoids or any other rectal or bowel problems?

General Digestion Problems: Past & Present

Acid Indigestion	☐ No	☐ Yes, in the past	☐ Yes, Currently
Acid Reflux	☐ No	☐ Yes, in the past	☐ Yes, Currently
Colitis	☐ No	☐ Yes, in the past	☐ Yes, Currently
Constipation	☐ No	☐ Yes, in the past	☐ Yes, Currently
Diarrhea	☐ No	☐ Yes, in the past	☐ Yes, Currently
Diverticulitis	☐ No	☐ Yes, in the past	☐ Yes, Currently
Hiatal Hernia	☐ No	☐ Yes, in the past	☐ Yes, Currently
Irritable Bowel Syndrome	☐ No	☐ Yes, in the past	☐ Yes, Currently
Ulcers	☐ No	☐ Yes, in the past	☐ Yes, Currently

Female Gynecological History:

Age menses began_____Number of flow days_____Cycle length_____

Date of last menstrual period_____

Excessive Cramping ☐ Yes ☐ No

Excessive flow ☐ Yes ☐ No

Bleeding or spotting between periods ☐ Yes ☐ No

Any Abnormal Discharge? ☐ Yes ☐ No

Are cycles regular ☐ Yes ☐ No

Experience symptoms of premenstrual tension ☐ Yes ☐ No

Do you have a history of any of the following vaginal infections?

☐ Yeast ☐ Gonorrhea ☐ Syphilis ☐ Herpes ☐ Chlamydia ☐ Vaginitis

Do you have a history of ovarian cysts, uterine fibroids, or endometriosis? if so please explain:

Date of last PAP:_____ ☐ Normal ☐ Abnormal

Have you ever had an abnormal PAP if so when?

Please list the number of each of the following:

Pregnancies: Live Births: Miscarriages: Abortions:

Type of birth control Difficulty conceiving ☐ Yes ☐ No Pain on intercourse ☐ Yes ☐ No

Menopausal symptoms (list):

Sexually active ☐ Yes ☐ No Having sexual difficulties ☐ Yes ☐ No

Sexual preference (optional) ☐ Heterosexual ☐ Bisexual ☐ Lesbian

Breasts:

I do self-exams regularly ☐ Yes ☐ No Consistently have lumps ☐ Yes ☐ No

Nipple Discharge ☐ Yes ☐ No Any pain or tenderness ☐ Yes ☐ No

Implants ☐ Yes ☐ No

Have you ever had a mammogram? ☐ Yes ☐ No If so when? -- ☐ Normal ☐ Abnormal

Comments:

Sedona Wellness Retreat & Lodge at Sedona

At the Sedona Wellness Retreat we treat and help to prevent diseases by natural means. Your Naturopathic Medical Doctor will take a thorough case history, a screening physical examination. It is very important therefore that you inform your Naturopathic Medical Doctor immediately of any disease process that you are suffering from, if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or you are breast feeding; please advise your Naturopathic Doctor immediately. There are health risks to treatment by naturopathic medicine. These are rare, but include, and are not limited to: possible aggravation of pre-existing symptoms, allergic reactions, pain, bruising, headaches, nausea, weakness, fever, diarrhea, fainting, drowsiness and other consequences.

DISPENSARY

All dispensaries must be paid for at time of purchase and are subject to a state sales tax. Credit on account will be given for unopened items in sellable condition returned within 7 days. Injectables, injection supplies, special orders and products packaged in the clinic cannot be returned. I agree to make payments according to the policies of The Wellness Retreat & Center. I understand that some or all of the services I receive may not be covered or may have coverage limitations or restrictions under my program. It is my responsibility to know what my program includes.

STATEMENT OF ACKNOWLEDGMENT

As a patient of the WELLNESS RETREAT, I have read the information and understand that my identity will be protected at all times and, if necessary, identifying information will be altered to protect my privacy. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself in writing or unless law requires it. I understand that I may look at my medical record at anytime and can request a copy of it by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential. I give the right to photograph and video me and use such in a professional manner they see fit. The information I have provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for: _____.
I intend this consent form to cover the entire course of the program or treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I also confirm that I have the ability to accept or reject this care of my own free will and choice. I accept full responsibility for any fees incurred during care and treatment.

PAYMENT POLICIES

Full payment for all charges is required BEFORE start of program and therapies. In special circumstances, the doctor may arrange differently. We accept payment by a cashiers check, cash, or credit card. NO Personal Checks. A minimum billing fee of $5.00 monthly AND 15% APR will be added to any unpaid balance after 30 days.

REFUNDS AND CANCELLATIONS

If we have to cancel a retreat, all pre-paid reservations will be refunded in full immediately. Cancellations that are made before 31 days before the retreat start date will receive a 50% refund. Cancellations made less than 31 days before the retreat start date will not receive a refund. You can change the dates of the retreat before 31 days of the retreat start date with no additional charge. Just let us know. Your deposit can be used up to 6 months from date of reservation. Minimum stay for the retreat is 2 week, and will be charged the minimum of 2 week stay even if you have to cancel early for any reason. Booking for any retreat requires a reservation fee up to thirty days before arrival date.

Patient Name: (Please Print) _____Date:_____

Signature of Patient or Guardian: _____

Person Responsible for Payments: _____Signature_____

Please send signed form back to info@SedonaWellnessRetreat.com // Fax: 1-866-503-4341

RETRETAT PATIENT INFORMED CONSENT

I have been told by my doctors that there are standard, traditional approaches of treatment for my condition(s), and for personal reasons I am choosing to use alternative therapies under the direction of licensed Naturopathic Medical Doctors, instead of or in addition to these standard, conventional therapies. My family is aware of my choice and supports me.

I have decided to embark on alternative medicine at the Sedona Wellness Retreat, to detoxify my body and strengthen my immune system. I have asked Sedona Wellness Retreat at the Lodge at Sedona to assist me in this process by monitoring my progress and suggesting appropriate therapies. I am aware that these are non-conventional therapies, that there may be no proven benefit over more traditional modalities, and I have been given no promise of success, cure or remission or other effect of treatment. I am aware of the possibility of beneficial as well as adverse effects. I understand that by making this decision, I have assumed complete and total responsibility for my own health and I release, and hold harmless Sedona Wellness Retreat, The Lodge at Sedona and any affiliate or agent from any liability whatsoever arising from the services rendered to me or on my behalf.

Patient name (printed):_____

Patient signature:_____

Witness:_____

Date:_____

Sedona Wellness Retreat -- Consent for Therapy

Please read and initial each paragraph and print and sign your name after you have read and understand the information.

Intravenous/Intra-articular/Subcutaneous/Intramuscular Therapy: As is the case with any therapeutic substance administered intravenously (IV), intramuscularly (IM), subcutaneous injection, or intra-articular, the possibility of mild and rare side effects are possible such as pain, irritation, or burning at the site of infusion, temporary sensations of tingling, numbness, or pins and needles around the mouth, fever, nausea, diarrhea, headache, or feeling of weakness. I have been informed that there may be some significant risks, such as allergic reactions, injury, bleeding, bruising, fainting, drowsiness, and other consequences. I have been informed that these therapies include intramuscular injections (IM), intravenous (IV) infusions, subcutaneous injection, or intra-articular injections of vitamins, minerals, amino acids, hormones, hydrogen peroxide, herbs, gas, light and other molecules and metabolites; some of these products/approaches are not FDA-approved or evaluated for any disease or condition, and are not considered the standard of practice in mainstream medicine.

EDTA: consists of a synthetic amino acid called ethylene diamine tetraacetic acid (EDTA). When EDTA is introduced into your body though an intravenous infusion, the protein like material binds with and chelated certain minerals and metals that are present in your bloodstream and eliminated them through the bowels and kidneys. In laboratory investigations comparing the toxicity of EDTA injection therapy with other drugs commonly used by Americans, it was found that an equivalent therapeutic dosage of EDTA is safer then one aspirin tablet, a dose of digitoxin, a tetracycline capsule, a teaspoonful of ethyl alcohol, or the nicotine in two cigarettes. I have been informed about the various forms of chelation therapy and clearly understand that the Sedona Wellness Retreat uses Calcium Disodium EDTA, which is infused over a period of 3-10 minutes.

I have been informed that these therapies may not be approved by the FDA and are considered investigational or experimental and that data collected from my participation in these therapies may be used to further the understanding and treatment of disease. This included but not limited to published data, presenting papers in public or private, seminars, lectures and/or journals, or sharing this information with other professionals. I understand data collected from my treatments, if presented, will be kept anonymous and that my confidentiality will be protected at all times. I understand that although the FDA has not approved the use of these therapies, the lack of approval does not render the use of these therapies such as ozone, hydrogen peroxide, and chelation unlawful. In North America, these therapies are considered investigational or experimental.

I have read and understand the handouts/fliers on the therapies provided by the Natural Wellness Center and have been informed about the specific procedures involved with the administration of the treatments for therapeutic purposes. I desire to undergo this program after having considered the information contained in the information provided to me through my conversations with treating physician and through materials provided to me by the office to educate me about the program.

I understand that there have been no warranties, assurances, or guarantees of success made to me as to result or cure, and I will not hold the physician responsible for my individual result(s) of the treatment(s) that I have requested. I fully understand that there are other alternative treatments available for my condition. The following are a list of alternative treatments available, however, this list is not in any way considered conclusive of all other available treatments: neuro-stim, neural therapy, trigger point therapy, chelation, detoxification, nerve blocks, prolotherapy, acupuncture, homeopathy, ozone therapy, diet, and nutritional supplements.

I acknowledge that I have had the opportunity to ask any questions of my physician with respect to the proposed therapy and the procedures to be utilized and all of my questions have been answered to my full satisfaction. My signature on this agreement will constitute a full and final release of any legal responsibility resulting from the administration of treatment in my case, and / or any other medical treatment that may be necessary as a result thereof.

I understand that once I have started my treatment program there are no refunds. I understand that my treatment program must be completed within 12 months from date of purchase. I also understand that my program is not transferable.

I understand that the physician will rely on statements made by me to determine that the procedure is safe and effective for me. WE STRONGLY RECOMMEND THAT IN ADDITION TO OUR CARE YOU MAINTAIN A RELATIONSHIP WITH ONE OR MORE PHYSICIANS QUALIFIED TO CARE FOR HEALTH CONDITION(S). I have informed the physician of all my known physical conditions, medical conditions, and medications. I hereby acknowledge that I do not have any kidney disease, active tuberculosis, lesions occupying space in the cranium, pregnancy, or gross mineral or vitamin deficiency. I assume all responsibility and liability for any condition(s) I have failed to disclose. I hereby authorize these injections and treatments. I choose to do this of my own free will.

_____	_____	_____
Patient Signature	Date	Print Patient's Name

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Arizona law, and not by a lawsuit or resort to court process except as Arizona law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

Article 2: All Claims Must Be Arbitrated: It is the intention of the parties that this agreement shall cover all existing or subsequent claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against a Physician, including any fee dispute, whether or not the subject of any existing court action shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing-the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select an arbitrator who was previously a court judge. Both parties agree the arbitration shall be governed pursuant to Arizona Revised Statutes (ARS) 12-1501-12-1518 and the Federal Arbitration Act (9 U.S.C 1-4), and that they have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: Revocation: This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 5: Severability Provision: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed there from and the remainder of the Agreement enforced in accordance with Arizona and federal law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____
Physician or Duly Authorized Representative Signature (Date)

By: _____
Patient's Signature (Date)

By: _____
Print or Stamp Name of Physician, Medical Group or Association Name

By: _____
Print Patient's Name

By: _____
Signature of Translator (if applicable) (Date)

By: _____
Patient's Representative's Signature (Date)

_____
Print Name of Translator

_____
Print Name and Relationship to Patient

A signed copy of this document is to be given to the patient. The Original is to be filed in Patient's medical records.

Arbitration Agreements - Frequently Asked Questions

The following are frequently asked questions about arbitration in general, the arbitration process and arbitration agreements. If you have any additional questions, we encouraged to seek further explanation from a legal advisor, or published legal material relating to arbitration.

Q. What is arbitration?
Q. Do I have a right to my own attorney?
Q. Who is an arbitrator?
Q. Who selects the arbitrator?
A. Arbitration is an alternative to the jury system. Arbitration Changes the forum in which a patient-doctor dispute will be heard. Thus, in arbitration, an arbitrator (usually a retired judge) will hear the case as opposed to a jury. The patient and the doctor chose the arbitrator, who then hears and decides the outcome of the claim or dispute. You may retain an attorney of your choice to represent you in arbitration, just as you would in a jury trial.

Q. Is arbitration legal in Arizona?
A. Yes. In 2005, the Arizona State Legislature approved the use of arbitration agreements in medical malpractice disputes. (See 2005 Arizona Code - Revised Statutes §12-133.)

Q. Can I still sue the doctor?
A. Yes, you still have the right to sue the doctor. Signing the arbitration agreement only changes the forum (from jury to arbitrator) which will hear and decide your dispute.

Q. By signing this agreement, does this mean that I am suing the doctor?
A. No, it does not. The arbitration agreement is not related to any present or pending legal proceeding against the physician. It is a document that defines an alternative process for resolving a dispute, should a dispute arise in the future.

Q. Does signing the arbitration agreement take away my right to a jury trial?
A. Yes, it does. Both you and the doctor are agreeing to waive the right to a jury trial, that is, both parties are agreeing to replace the jury trial with arbitration.

Q. Will the doctor see me if I do not sign the arbitration agreement?
Q. Why are you asking me to sign an arbitration agreement now? I have been a patient for years.
Q. I am only here for a consultation. Do I still need to sign an arbitration agreement?
Q. May I take the arbitration agreement home to review it before I sign?
A. The doctor has asked that all new and continuing patients be offered the arbitration agreement, regardless of the reason for the office visit. We prefer that you complete all paperwork before seeing the doctor. Should you want a copy of the agreement to take home with you, you will be provided it upon request.

Q. Is arbitration only used by physicians and hospitals?
A. No. Arbitration has been used in Arizona for years in a variety of industries or businesses, including, (among others) real estate, entertainment, and health insurance companies. Arbitration is also used to resolve disputes between employees and employers.

Q. May I have a copy of the laws referred to in the arbitration agreement?
A. Copies of the laws referenced in the arbitration agreement may be obtained from the library, or on the internet. Our doctor's office does not keep copies of these laws.

To Bring Anytime:

1. Comfortable casual clothing
2. Indoor shoes, i.e. slippers, sandals
3. Outdoor shoes, i.e. sturdy walking shoes, tennis shoes.
4. Toiletries, shave kit, your normal bathroom items.
5. Bathing Suit/Swim Suit, Sun screen, Sun hat (Summertime going to River)
6. Gym wear, clothing for exercise
7. Light Jacket & Hat - It can get a little cool here in the evenings.
   (Warm Jacket, Hat & Gloves during the months of October - March)
8. Hiking clothes: Shorts, T-shirts, Pants, Sweater
9. Backpack
10. Photo ID, Credit Card, Money, Camera...
11. Dry Weather: Chapstick, Nose Spray, Skin Moisturizer and Lotion
12. Reading materials, books, journal, dvd's . . .

If you forget something or need something while you are here we very likely can accommodate you, and there are stores in the area.

Please note we are a very relaxed retreat, so don't worry about bringing too much stuff.

Sedona Yearly Temperatures:

Month	Daily High	Daily Low	Precipitation
January	55.0 F	29.7 F	1.70 inches
February	59.1 F	32.2 F	1.54 inches
March	63.3 F	35.0 F	1.67 inches
April	72.1 F	42.1 F	1.17 inches
May	81.2 F	49.2 F	0.58 inches
June	90.7 F	57.2 F	0.49 inches
July	95.1 F	65.1 F	1.89 inches
August	92.3 F	63.7 F	2.42 inches
September	88.3 F	58.1 F	1.51 inches
October	77.9 F	48.5 F	1.1 inches
November	65.1 F	36.9 F	1.32 inches
December	56.4 F	30.5 F	1.73 inches

Dry Climate: It is Dry here in Sedona. We are in the High Desert.

Elevation: Sedona is at 4500 feet. It may take a few days to acclimate to the elevation.

The retreat is surrounded by forests and there are many trails in the area for beginners and experts. The Grand Canyon is 2 hours away for a perfect day trip.

Healing Vortex: There are 5 healing vortex's in Sedona.

Sedona Wellness Retreat

Credit Card Authorization Form

The attached document is our Credit Card Authorization form, and below are instructions to completing the form:

1. We ask that you fill in all the blanks on the Credit Card Authorization form. Each blank is imperative in the processing of the payment.

2. Please provide your contact information, where you can be reached (i.e. telephone number and/or email address), in the event that the Wellness Retreat cannot process the payment.

3. Please be sure to specify the charges that you would like charged on the given credit card.

4. Please remember to send a legible copy of the credit card and identification (drivers license). We ask that the account number, be clear.

5. Once you have filled out the below form, please submit the form and the copy of the credit card to 1-866-503-4341, our Wellness Retreat office.

6. In order to process the payment to the credit card, please submit your paperwork to confirm reservation.

7. In the event that the Wellness Retreat Center cannot process the payment, and the point of contact on the below form cannot be contacted you may lose your reservation.

If you should have any questions, you may contact the Wellness Retreat Center at 928-613-2233.

www.naturalwellnessretreat.com - Honolulu, Hawaii
www.sedonawellnessretreat.com - Sedona, Arizona
Hawaii - Wellness Retreat - Sedona
2752 Woodlawn Dr. #5-110; Honolulu, HI 96822 \\ 125 Kallof PL; Sedona, AZ 86336
(928) 613-2233 // F: (866) 503-4341
info@naturalwellnessretreat.com

Authorization to Charge Credit Card

- Complete Form & fax back to 866-503-4341

Guest Name: _____

Arrival Date: _____Departure Date: _____

Point of Contact's Telephone Number: _____

Point of Contact's Email Address: _____

Name of Card Holder: _____

Billing Address:_____

_____

_____

Credit Card Type: _____

Credit Card Number: _____Exp. date_____

Credit Card Verification Code: _____Billing Zip Code:_____

Billing Information

Reservation Amount:_____

Additional Charges: _____

Other/Estimated Amount:_____

I authorize the Sedona Wellness Retreat to bill the above charges to my credit card.

Card Holder's Signature: _____

*** Please include a LEGIBLE photocopy of the front of the Credit Card***

Include a copy of a valid State ID such as a driver's license

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