PATIENT CONDITIONS OF TREATMENT AND INFORMED CONSENT TO TREAT

Clinic Treatment(s) This document is a binding agreement (the "Agreement") between Vance Medical and/or Dr. Mark Vance dba Vance Medical (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:

1. Consent for Treatment. You hereby consent to and authorize Us to provide You with health care treatment, including but not limited to medical, diagnostic, nutritional/supplement treatment, PEMF, Intravenous and Intramuscular Micronutrient Therapy, Ultraviolet Blood Irradiation, Major Autohemotherapy, Chelation, Plaquex, Nicotinamide Adenine Dinucleotide (NAD) Therapy, Manual Therapies, Low Dose Immunotherapy and Low Dose Allergen Therapy, Low Dose Naltrexone, PTSD Treatments, Ozone Treatments (Including Ozone Insufflation, Nozone, and Otozone), Biodentical Hormone Therapy, Hormone Pellet Therapy, RHP/EBOO or Ozone Dialysis, Neural Therapy, Trigger Point Injections, Perineural Injection Therapy and Prolozone(together the "Treatments") administered by Us, our physicians, assistants, consultants and staff. You understand that the practice of health care/medicine 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. Experimental Nature of Treatment. You acknowledge and agree that the evaluation, diagnosis and treatments may consist in whole or part of experimental procedures and methods, including but not limited to PEMF, Intravenous and Intramuscular Micronutrient Therapy, Ultraviolet Blood Irradiation, Major Autohemotherapy, Chelation, Plaquex, Nicotinamide Adenine Dinucleotide (NAD) Therapy, Manual Therapies, Low Dose Immunotherapy and Low Dose Allergen Therapy, Low Dose Naltrexone, PTSD Treatments, Ozone Treatments (Including Ozone Insufflation, Nozone, and Otozone), Biodentical Hormone Therapy, Hormone Pellet Therapy, RHP/EBOO or Ozone Dialysis, Neural Therapy, Trigger Point Injections, Perineural Injection Therapy and Prolozone(together the "Treatments") 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.

3. Risks, Side Effects, Complication. We hereby inform You that there are certain unavoidable risks and potential side effects and complications to the Treatments, including but not limited to infection; swelling; increased pain; bleeding; vein irritation and hardening; temporary numbness; lightheadedness; nausea; vomiting; dizziness; allergic or anaphylactic reaction; bruising; pain at IV site; acute vs. chronic liver or kidney dysfunction; scarring; headaches; gastrointestinal upset; shortness of breath; chest tightness; transient blindness; blood clots; embolism; fluid overload; a flushed feeling; warmth in the body; low or high blood pressure; low or high blood sugar; temporary or permanent alteration in sensation; discoloration; the need for additional surgery; soreness, itching, injury to nerves; spinal cord injuries; numbness; tingling; dural leaks; positional headaches (feel worse when sitting up, better when lying down); neck pain or stiffness; change in hearing (muffled sounds, ringing ears, etc); sense of imbalance; photophobia; phonophobia; pain between shoulder blades; drainage from nose; drainage from ears; salty or metallic taste in mouth; sense of drainage down back of throat; cutaneous sinus tract drainage; loss of smell; spinal fluid leaks; pneumothorax (air on the outside of the lung); paralysis; no benefit from Treatments; any other known or unknown complications or side effects; or other serious or debilitating injuries or death. You understand that other complications and risks are possible and that healing does not always proceed in a predictable manner and may take many weeks or months to experience full effect.

4. Description of Treatments. 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, Lidocaine, lidocaine w epinephrine, bupivacaine or ropivacaine), sugar water or dextrose, and, on occasion 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 actually administer the Treatments.

5. Health Care Staff. You are aware that among those who attend you on our behalf may be medical, nursing, and other health care 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. 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 covenant that all the information You provide Us during the course of Treatments, including without limitation the information required by this Section 6, is true, accurate, complete and up-to-date to the best of Your knowledge.

7. 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 question 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 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.

8. Alternatives. You have been informed that there are alternatives to the Treatments including surgery, other types of injections, prescription medications and taking no action. You further acknowledge that You have not been advised against seeking any other medical examinations or treatments.

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 Idaho without regard to any choice of law principal. Any dispute between you and Us shall be adjudicated in state or federal court in Boise, Idaho, and You submit to the jurisdiction of any such court.

10. Email Consent: I consent to receive communications sent from Vance Medical and/or Dr. B. Mark Vance, MD, via U.S. mail and/or email. I understand that I may unsubscribe from any automated communication at any time.

11. Acknowledgement and Voluntary Consent. I have read the Patient Conditions of Treatment and Informed Consent to Treat or have had it read to me, and agree to be bound by the terms therein. I have not signed this declaration without first reading it or having it read to me and I may ask any questions useful in helping me to understand it. I further understand my agreement to the provision of this declaration is an entirely voluntary and informed choice to which my signature attests.

12. Intent to Seek Services. By your signature You attest that You have not engaged in the service of Dr. Vance or those employed by Vance Medical in order to file a malpractice suit or further any investigation or prosecution by any government entity or medical association. Your sole purpose and intent in seeking the services of Dr. Vance and Vance Medical is to get help for Your personal health issues.

Patient Name/Signature: _____ Date: _____

(If Patient is a Minor)

Guardian Signature _____ Date: _____

Relationship to Minor :_____