MAUI REGENERATIVE MEDICINE

PATIENT HISTORY INFORMATION

Name Date

Address State / Zip Code

Phone Home Cell

Age Date of Birth Sex M F

Maritial Status: S M W D Spouse Name

Patient Email Address:

Emergency Contact:

How did you find out about our office?

What is the reason for this visit?

Is this condition due to: Auto Accident Work Injury Other Accident Illness Other

Are symptoms: Improving Getting Worse About The Same Intermittent

Have you seen any of the following doctors for this? MD Naturopathic Dr

Chiropractor Acupuncturist Doctor's Name:

Therapy Received: Dates Treated:

Diagnosis:

Medical History:

Medications Prescribed:

Medication Allergies:

I understand that a 24 hour advance notification is required for scheduling or cancelling of appointments to avoid a charge. I understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. In the event of default, I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees may be required to effect collection.

Patient Signature: _____ **Date:** _____

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Dr.Kevin Davison N.D.,L.Ac

Patient Conditions of Treatment and Informed Consent to Treat

This document is a binding agreement (the "Agreement") between Maui Regenerative Medicine LLC. ("We" "Us" "Our") and the individual patient whose name and signature appears below ("You" "Yours"). In consideration of the health care service which may be 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 line following each section and by signing in the space provided):

1. **Consent For Treatment.** You understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risk of injury or death. You hereby consent to and authorize us to provide you with health care treatment which, depending on your health conditions, may include without limitation one or more of the following procedures: naturopathic medicine, dietary, herbal, medical, pharmaceutical and anesthetic treatment, Minor Surgery, Gynecology, Radiofrequency procedures, Acupuncture, prolotherapy and/or Platelet Rich Plasma injections, Cellular Therapy injections, Intravenous Micronutrient and Botanical Therapy and Heavy Metal Chelation. Together the "Treatments" administered by us, physicians, registered nurses, assistants, and/or consultants and staff. You acknowledge the We have not made any guarantees or promises as to the outcome or the safety and efficacy of the Treatments. **(Initials)___**

2. **Experimental Nature of Treatment.** You acknowledge and agree that the Treatments may consist in whole or part of experimental procedure and methods, including without limit Acupuncture, Intravenous Micronutrient Therapy, Minor Surgery, Prolotherapy, Platelet Rich Plasma therapy, and Cellular Therapy, on which no governmental (including the U.S. Drug Administration ("FDA"), scientific or medical authority has confirmed the safety or efficacy therefore, You acknowledge that the safety and efficacy record of the Treatment is based only on empirical and anecdotal evidence, which only shows that the Treatment appear to be relatively safe and effective. We have informed you that the Treatments MAY alter, address or decrease Your pain, symptoms or complaints, but also may have no effect. **(Initials)** ___

3. **Minor Surgery, Prolotherapy, Injection Therapy Risk, Side Effects, Complications.** We hereby inform you that there are certain unavoidable risks and potential side effects and complications to the Treatments, including without limitation swelling; increased pain; bleeding; dizziness, numbness; scarring; scar or keloid formation; asymmetry; allergic reaction; discoloration; soreness, itching, a feeling of "lumpiness" or permanent skin contour irregularities at the site of Treatments;, all of which may be permanent. Treatment may very rarely cause infection; injury to nerves, temporary or permanent alteration in sensation; the need for additional surgery or hospitalization; spinal cord injuries. Pneumothorax (temporary lung collapse), paralysis, or other serious or debilitating injuries or death. **(Initials)** ___

4. **Description of Treatment.** The exact procedure, as well as the recommended sequence of Treatment, will be explained to You when We actually administer the Treatment. You acknowledge that any of the Treatments may involve insertion of needles into Your skin and veins and injection of standardized formulas which may include various nutritional substances, hormones, homeopathic medicines and FDA approved prescription medicines, chelating agents, local anesthetic (Procaine, Bupivacaine, Lidocaine, Ropivacaine) concentrated sugar water or dextrose, concentrates or Your own blood (Platelet Rich Plasma, Bone Marrow Stem Cells, Fat Derived Stem Cells) and,on occasion, other substances and local subcutaneous anesthetic infiltration (with or without epinephrine)which will be explained to you before injection. **(Initials)** ___
5. **Medical Staff.** You are aware that among those attending You on Our behalf are medical, nursing and other health care personnel employed by Us or in training, who unless requested otherwise, may participate in Your patient care. **(Initials)** ___

6. **Information You Provide Us.** You have provided us with a complete list of all prescription and nonprescription medications and dietary supplements You are currently taking, and a complete list of all known allergies You may have, and all allergic or adverse reactions You have had in the past to any medications, dietary supplements or medical treatments of any kind. You agree to update Us periodically should the list change. **(Initials)** ___

7. **Assumption of Risk.** You hereby acknowledge 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 risk associated with the Treatments, including without limitation those described in this Agreement. You acknowledge that no explanation or description of the Treatment can ever fully explain every possible risk, side effect or complication that may/or could arise from the treatment, but that by initialing and signing this Agreement, You nevertheless acknowledge Your willingness to assume such risk and that You consent to the Treatment is willing, voluntary and informed. **(Initials)** ___

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. **(Initials)** ___

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 provisions shall be curtailed, limited or served only to the extent necessary to remove such illegality or invalidity. This Agreement shall be governed by the laws of the State of Hawaii without regard to any adjudicated in state or federal court in Maui County, Hawaii and You Submit to the jurisdiction of any such court. **(Initials)** ___

BY SIGNING THIS AGREEMENT, YOU INDICATE THAT YOU HAVE READ, UNDERSTAND AND AGREE TO ITS TERMS, YOU HAVE RECEIVED A COPY OF THIS AGREEMENT, AND THAT YOU ARE THE PATIENT, GUARANTOR, THE PARENT'S LEGAL REPRESENTATIVE OR LEGALLY AUTHORIZED TO SIGN THIS AGREEMENT AND ACCEPT ITS TERMS.

Patient **Legal Guardian/Proxy/Representative**

_____ _____

Signature **Date** **Signature** **Date**

_____ _____

Printed Name **Printed Name of person signing**

Physicians Certification I hereby certify that one of my associates or I have explained to the patient or authorized person that the nature of the proposed treatments, the medically significant alternatives, and inlay terms the purpose, likelihood of success, benefits, and reasonably foreseeable risk, complications, and consequences of treatment. The patient or person authorized has had the opportunity to ask questions and has stated that no further explanation was desired.

Physicians Signature _____ ***Date*** _____

NAME (PLEASE PRINT): _____ DATE: _____

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

S= STIFFNESS B = BURNING N=NUMBNESS
P= SHARP PAIN T = TINGLING D=DULL PAIN