Recapture your Life

West Valley Naturopathic Center

Dear New Patient,
We are very excited to welcome you to West Valley Naturopathic Center. Within this letter you will find the following: our policies, a website for the new patient forms, the physical address of our office, and a map of ouroffice location.

At the time of scheduling, we take a $25 ***NON-REFUNDABLE*** deposit that gets deducted off of the total cost of your visit. If you should need to reschedule your appointment, it must be before 24 business hours of your scheduled appointment time. The initial deposit will be held for the rescheduled appointment up to 3 months. If your appointment is not rescheduled within 3 months of the initial deposit payment, another $25 deposit is requiredto reschedule.

The new patient forms can be found on our website at www.wvncaz.com/forms. We require the new patient forms to be filled out and submitted at least 48 hours prior to your scheduled appointment time. If we do not receive the new patient forms in the allotted time frame, we will have to reschedule your initial appointment. Our office blocksout an hour time slot solely dedicated to your appointment and we do not double book patients. Having your new patient forms before the visit helps ensure the doctors are able to stay on schedule with your appointment and the patients after you.

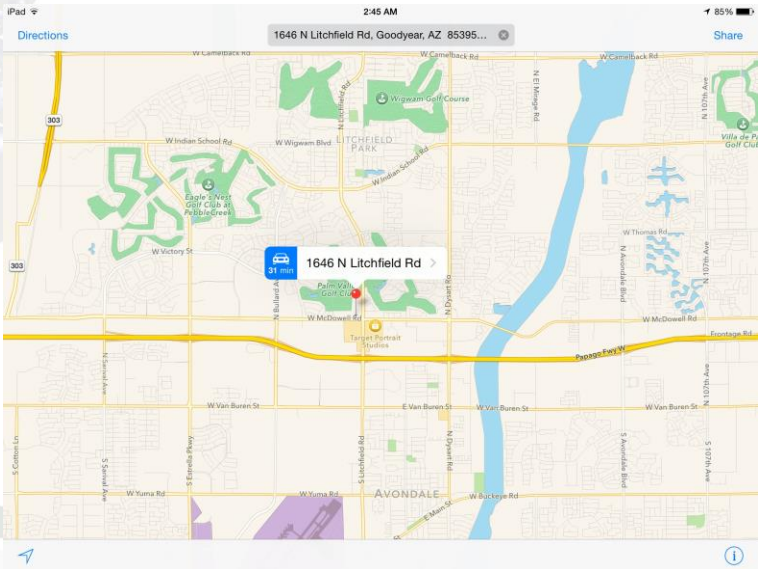
Our office is a cash pay office and your service fee is based on the amount of time spent with the doctor only. Ifyour initial 60 minute consult was to go over the allotted time, an additional charge will be applied.

You will receive text reminders 48 hours before your scheduled appointment time as a reminder. You will also be given a call by our front office staff to confirm your appointment.

Items to bring with you to your initial visit: recent labs, recent imaging, health insurance card, drivers license, list ofcurrent supplements and medications, and any other pertinent medical records.

We are at your service to assist you on your journey to optimizing your health and wellness. Please do not hesitate to contact us directly if you have any additionalquestions or concerns. We look forward to meeting youand we are truly excited that you have chosen our officeto facilitate your health care needs.

In health,
The WVNC team



(T) 623.643.9598. (W) www.wvncaz.com. (E) admin@wvncaz.com
1646 N. Litchfield Rd #200 Goodyear, Az 85395

Neural Prolotherapy Informed Consent

You have the right to be informed of the procedure, any feasible alternative options, and the risks and benefits. Except in emergencies, procedures are not performed until you have had an opportunity to receive such information and to give your informed consent.

I have been advised of the following:

1. This procedure is an established technique for reducing pain.
2. This technique requires an injection of a 5% dextrose solution.
3. Multiple injections are done along the subcutaneous nerves. It has been established that irritation to a nerve that supplies sensation to the skin may also cause dysfunction and pain to the tissue underneath. The procedure has been used on thousands of patients and has been proven generally safe. Adverse reactions and severe complications are rare.
4. This treatment may decrease pain but may not completely eradicate it.
5. Multiple treatments may be required to achieve the patient's desired reduction and/or elimination of pain.

I have been advised that the alternatives to this procedure include:

- Do Nothing
- Physical Therapy
- Pharmaceutical Management
- Surgical Intervention
- Osteopathic or Chiropractic Manipulation

I understand that any procedure has inherent risks associated with it. I have been advised that the possible risks and complications of injections may include, and are not limited to:

- Immediate pain at the injection site
- Allergic reaction
- Spinal cord injury during any treatment over the spinal column
- Pneumothorax (partial or complete collapse of the lung)
- Infection at the injection site
- Injury to nerves, arteries, veins, and muscles at the injection site
- Temporary or permanent nerve paralysis
- Death from complications of the treatment
- There may be no effect from the treatment

Your signature below indicates that:

- You understand the information provided on this form and agree to the procedure.
- Your physician has adequately explained the procedure(s) set forth above to you.
- You have received all the information and explanation you desire concerning the procedure.
- You authorize and consent to the performance of the procedure(s).

Patient Name (printed): _____

Patient Signature: _____ Date: _____