1231 Country Club Drive
Carson City, NV 89703

The Nevada Center

(775) 884-3990
Fax (775) 884-2202

Policies & Fees

Please Note:

1. A 50% deposit is required for all new patient office consultations. This is collected at the time the appointment is booked.
2. All phone appointment fees area to be paid in full at the time the appointment is booked.
3. The deposit for your initial consultation is fully refundable if your appointment is cancelled 72 hours in advance, otherwise it will be forfeited. For Monday appointments the cancellation notice must be given on the prior Thursday.

Billing

We do not bill patients or insurance companies. Please be prepared to pay for all services at the time they are rendered. We accept check, cash, money order, Visa, Master Card, American Express and Discover. All bills are paid at the time of service, if not there is a $15.00 billing charge and a 2% service fee for each month balance is unpaid.

Insurance

At the end of each visit you will be given a completed form, which can be used for insurance reimbursement. You will need to contact your insurance company and ask how they would want you to submit the bill. Be sure that you read your policy very carefully and are familiar with your terms. Most insurance companies will cover office visits; however, supplements, IV therapies, specialized test, and Homeopathic Medications are usually not covered.

We can also refer you to an excellent professional insurance billing service. She does all forms electronically so the turn around on reimbursement is much quicker. If you are interested, we will be happy to give you all the information in regards to this service.

Medicare

Our office does not accept Medicare Insurance. Medicare does not cover Homeopathic/ Alternative Medicine. We do however offer our Medicare patients a 20% discount on office visits and 10% discount on procedures and products.

Phone Calls

We realize that your phone calls are an important part of our service to you. We will make every effort to return them as soon as we can. However, in a busy clinic phone messages can sometimes be misplaced, so if you don't hear from us in a timely manner, please call back.

Appointments

Please keep your appointment and please be on time. A missed or late appointment not only compromises your best care, but also can set the doctor back, causing a wait for all patients the rest of the day. An adequate cancellation notice will allow patients on the cancellation list to get in sooner. If you do not cancel with 24 hours you will be charged $50.00 for a no call no show fee. As a courtesy, we do give you a reminder call. If you do miss your appointment, please call to reschedule as soon as possible. We really appreciate your help with this policy.

Emergencies

Please call the clinic anytime you have an urgent problem. If it is not during our normal business hours the 24-hour directory will put you through to Dr. Shallenberger or the doctor on duty. or the physician assistant directly. Urgent matters only please.

PATIENT REGISTRATION FORM

Patient Last Name	First Name	Middle Initial

Mailing Address: _____

City: State: Zip:

Date of Birth	Age	Social Security Number	Marital Status

Home Phone #	Alternate Phone #	Referred by:

Employer	Occupation	Work Phone #

Spouse's Name	Spouse's Phone #

Name of nearest relative/friend not residing with you: _____ Their phone # _____

Their address:

Patient Signature: _____ Date: _____

BELOW SECTION TO BE COMPLETED BY PATIENT'S LEGAL GUARDIAN IF APPLICABLE

Please print guardian's name

Mailing Address: _____

City: State: Zip:

Relationship to patient	Date of Birth	Social Security Number

Guardian Signature: _____ Date: _____

PLEASE LIST ANY ALLERGIES TO MEDICATIONS ON THE BACK OF THIS FORM.

PLEASE LIST ANY ALLERGIES TO MEDICATIONS BELOW:

☐ Yes, I would like to receive emails from The Nevada Center.
My email address is: _____

☐ No, please do not send emails.

THANK YOU

Health Profile

NAME _____ DATE _____ WEEK _____

Rate each of the following symptoms based upon your typical health profile for: □ *Past 30 days* □ *Past 48 hours*

Point Scale		
0	*Never* or *almost never* have the symptom	
1	*Occasionally* have it, effect is *not severe*	
2	*Ocasionally* have it, effect is *severe*	
3	*Frequently* have it, effect is *not severe*	
4	*Frequently* have it, effect is *severe*	

HEAD
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia
_____ TOTAL

EYES
_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision (does not include near- or far-sightedness)
_____ TOTAL

EARS
_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss
_____ TOTAL

NOSE
_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation
_____ TOTAL

MOUTH/ THROAT
_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums or lips
_____ Canker sores
_____ TOTAL

SKIN
_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating
_____ TOTAL

HEART
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain
_____ TOTAL

LUNGS
_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing
_____ TOTAL

DIGESTIVE TRACT
_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain
_____ TOTAL

JOINTS / MUSCLE
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness
_____ TOTAL

WEIGHT
_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight
_____ TOTAL

ENERGY / ACTIVITY
_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness
_____ TOTAL

MIND
_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities
_____ TOTAL

EMOTIONS
_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression
_____ TOTAL

OTHER
_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge
_____ TOTAL

GRAND TOTAL _____

HEALTH HISTORY

Name _____ Date _____

Occupation _____ Age _____ Height _____ Sex _____ Number of Children _____

Marital Status: ❑ Single ❑ Partner ❑ Married ❑ Separated ❑ Divorced ❑ Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit: Date began:

_____ _____

_____ _____

_____ _____

List current health problems for which you are being treated: _____

_____

_____

_____

What types of therapies have you tried for these problem(s) or to improve your health over-all:

❑ diet modification ❑ fasting ❑ vitamins/minerals ❑ herbs ❑ homeopathy ❑ chiropractic ❑ acupuncture ❑ conventional drugs

❑ other _____

Do you experience any of these general symptoms EVERY DAY?

❑ Debilitating fatigue	❑ Shortness of breath	❑ Insomnia	❑ Constipation	❑ Chronic pain/inflammation
❑ Depression	❑ Panic attacks	❑ Nausea	❑ Fecal incontinence	❑ Bleeding
❑ Disinterest in sex	❑ Headaches	❑ Vomiting	❑ Urinary incontinence	❑ Discharge
❑ Disinterest in eating	❑ Dizziness	❑ Diarrhea	❑ Low grade fever	❑ Itching/rash

Current medications (prescription or over-the-counter): _____

_____

_____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

_____

Outcome _____

_____

_____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Do you consider yourself: ❑ underweight ❑ overweight ❑ just right Your weight today _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, etc.)?

_____

What are your current health goals: _____

_____

_____

_____

_____

Medical History

- ❑ Arthritis
- ❑ Allergies/hay fever
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Autoimmune disease
- ❑ Blood pressure problems
- ❑ Bronchitis
- ❑ Cancer
- ❑ Chronic fatigue syndrome
- ❑ Carpal tunnel syndrome
- ❑ Cholesterol, elevated
- ❑ Circulatory problems
- ❑ Colitis
- ❑ Dental problems
- ❑ Depression
- ❑ Diabetes
- ❑ Diverticular disease
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Epilepsy
- ❑ Emphysema
- ❑ Eyes, ears, nose, throat problems
- ❑ Environmental sensitivities
- ❑ Fibromyalgia
- ❑ Food intolerance
- ❑ Gastroesophageal reflux disease
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart disease
- ❑ Infection, chronic
- ❑ Inflammatory bowel disease
- ❑ Irritable bowel syndrome
- ❑ Kidney or bladder disease
- ❑ Learning disabilities
- ❑ Liver or gallbladder disease (stones)
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological problems (Parkinson's, paralysis)
- ❑ Sinus problems
- ❑ Stroke
- ❑ Thyroid trouble
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Sexually transmitted disease
- ❑ Seasonal affective disorder
- ❑ Skin problems
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Urinary tract infection
- ❑ Varicose veins

Other _____

_____

Medical (Men)

- ❑ Benign prostatic hyperplasia
- ❑ Prostate cancer
- ❑ Decreased sex drive
- ❑ Infertility
- ❑ Sexually transmitted disease

Other _____

_____

Medical (Women)

- ❑ Menstrual irregularities
- ❑ Endometriosis
- ❑ Infertility
- ❑ Fibrocystic breasts
- ❑ Fibroids/ovarian cysts
- ❑ Premenstrual syndrome (PMS)
- ❑ Breast cancer
- ❑ Pelvic inflammatory disease
- ❑ Vaginal infections
- ❑ Decreased sex drive
- ❑ Sexually transmitted disease

Other _____

Date of last GYN exam _____

Mammogram ❑ + ❑ –

PAP ❑ + ❑ –

Form of birth control _____

# of children _____

# of pregnancies _____

❑ C-section _____

Age of first period _____

Date - last menstrual cycle _____

Length of cycle _____ days

Interval of time between cycles _____ days

Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____

- ❑ Surgical menopause
- ❑ Menopause

Family Health History (Parents and Siblings)

- ❑ Arthritis
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Heart disease
- ❑ Infertility
- ❑ Learning disabilities
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological disorders (Parkinson's, paralysis)
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Stroke
- ❑ Suicide

Other _____

Health Habits

❑ Tobacco:

Cigarettes: #/day _____

Cigars: #/day _____

❑ Alcohol:

Wine: #glasses/d or wk _____

Liquor: #ounces/d or wk _____

Beer: #glasses/d or wk _____

❑ Caffeine:

Coffee: #6 oz cups/d _____

Tea: #6 oz cups/d _____

Soda w/caffeine: #cans/d _____

Other sources _____

❑ Water: #glasses/d _____

Exercise

- ❑ 5-7 days per week
- ❑ 3-4 days per week
- ❑ 1-2 days per week
- ❑ 45 minutes or more duration per workout
- ❑ 30-45 minutes duration per workout
- ❑ Less than 30 minutes
- ❑ Walk - #days/wk _____
- ❑ Run, jog, other aerobic - #days/wk _____
- ❑ Weight lift - #days/wk _____
- ❑ Stretch - #days/wk _____
- ❑ Other _____

Nutrition & Diet

- ❑ Mixed food diet (animal and vegetable sources)
- ❑ Vegetarian
- ❑ Vegan
- ❑ Salt restriction
- ❑ Fat restriction
- ❑ Starch/carbohydrate restriction
- ❑ The Zone Diet
- ❑ Total calorie restriction

Specific food restrictions:

❑ dairy ❑ wheat ❑ eggs

❑ soy ❑ corn ❑ all gluten

Other _____

Food Frequency

Number of servings per day:

Fruits (citrus, melons, etc.) _____

Dark green or deep yellow/orange vegetables _____

Grains (unprocessed) _____

Beans, peas, legumes _____

Dairy, eggs _____

Meat, poultry, fish _____

Eating Habits

❑ Skip meals - which ones _____

_____

- ❑ One meal/day
- ❑ Two meals/day
- ❑ Three meals/day
- ❑ Graze (small frequent meals)
- ❑ Generally eat on the run
- ❑ Eat constantly whether hungry or not

Current Supplements

- ❑ Multivitamin/mineral
- ❑ Vitamin C
- ❑ Vitamin E
- ❑ EPA/DHA
- ❑ Evening Primrose/GLA
- ❑ Calcium, source _____
- ❑ Magnesium
- ❑ Zinc
- ❑ Minerals, describe _____
- ❑ Friendly flora (acidophilus)
- ❑ Digestive enzymes
- ❑ Amino acids
- ❑ CoQ10
- ❑ Antioxidants (e.g., lutein, resveratrol, etc.)
- ❑ Herbs
- ❑ Homeopathy
- ❑ Protein shakes
- ❑ Superfoods (e.g., bee pollen, phytonutrient blends)
- ❑ Liquid meals (Ensure)

Others _____

_____

I Would Like To:

ENERGY - VITALITY

- ❑ Feel more vital
- ❑ Have more energy
- ❑ Have more endurance
- ❑ Be less tired after lunch
- ❑ Sleep better
- ❑ Be free of pain
- ❑ Get less colds and flu
- ❑ Get rid of allergies
- ❑ Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- ❑ Stop using laxatives and stool softeners
- ❑ Improve sex drive

BODY COMPOSITION

- ❑ Loose weight
- ❑ Burn more body fat
- ❑ Be stronger
- ❑ Have better muscle tone
- ❑ Be more flexible

STRESS, MENTAL, EMOTIONAL

- ❑ Learn how to reduce stress
- ❑ Think more clearly and be more-focused
- ❑ Improve memory
- ❑ Be less depressed
- ❑ Be less moody
- ❑ Be less indecisive
- ❑ Feel more motivated

LIFE ENRICHMENT

- ❑ Reduce my risk of degenerative disease
- ❑ Slow down accelerated aging
- ❑ Maintain a healthier life longer
- ❑ Change from a "treating-illness" orientation to creating a wellness lifestyle

7/00, Rev 1/03, Rev 3/06

MET1392

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IMPORTANT MEDICAL LIABLILTY INFORMATION AND AGREEMENT TO ALTERNATIVE DISPUTE RESOLUTION

Dear patient, the cost of malpractice insurance has risen to unacceptable levels. Effective July 1, 2006, Dr. Shallenberger, will no longer have medical malpractice liability insurance. Dr. Shallenberger and the staff of The Nevada Center are consulting with legal, insurance, risk-management, and other professionals to try and resolve this issue. Until it is resolved, Dr. Shallenberger believes his patients should know that be is not insured for medical liability.

For the present, the only options are to close the clinic or to continue uninsured while trying to resolve this problem. In deciding to continue, Dr. Shallenberger will be instituting changes in his practice to more closely manage liability risk, but the intention is to continue to provide the same high quality of Homeopathic-Integrative medicine as that he has for the past 30 years.

We realize that, despite the best of care and intention, errors may occur, and medical errors may lead to harm. As part of our interim liability risk-management policy, all patients and/or their legal guardians are now asked to sign a copy of this form attesting to the fact that they are aware that Dr. Shallenberger does not have medical liability malpractice insurance.

In addition, we must now require that all patients formally agree to utilize alternative dispute resolution consisting of a two-step process: First, mediation, and second, if necessary, binding arbitration. This process would be instead of litigation and cover any and all legal disputes involving any professional actions of Dr. Shallenberger and/or the staff of The Nevada Center. This means that you are agreeing to waive your right to sue and to a trial by either judge or jury. You are further agreeing to exclusively submit any and all disputes relating to medical care that is provided by Dr. Shallenberger and/or staff of The Nevada Center first to mediation, and if no resolution is achieved by mediation, then to binding arbitration to be determined by a single arbitrator. The rules of the American Arbitration Association shall govern the mediation and binding arbitration and all proceedings shall be conducted pursuant to the rules of the American Arbitration Association.

These alternative dispute resolution methods are quicker and more cost effective in reaching an equitable solution for all parties involved. Because of the extreme overcrowding of the Court system and very high costs of litigation, these alternative dispute resolution methods are being increasingly employed as an alternative to the more costly and slower method of litigation by the judicial system.

The parties shall split the costs of mediating and disputes equally. Any attorney's fees incurred during mediation shall become a subject of the mediation and the parties will attempt to resolve attorney's fees during the mediation. The costs of binding arbitration shall be split between the parties equally and the arbitrator shall be empowered to award attorney's fees to the prevailing party.

Further, you agree that this agreement shall be governed by, construed, and enforced in accordance with the laws of the State of Nevada and subject to the jurisdiction of the First Judicial District Court of the State of Nevada in an for Carson City.

Dr. Shallenberger understands that some may feel uncomfortable in signing this form. If that is the case, please do NOT sign until you discuss it with an attorney. Although Dr. Shallenberger and the staff will not be able to provide any professional services to patients who choose not to sign, we will provide any medical records we have in our possession to you free of charge so that you can select the healthcare practitioner of your choice for your continued care.

BY SIGNING THIS FORM, YOU ARE FORMALLY AGREEING TO ABIDE BY THE TERMS DESCRIBED IN THIS DOCUMENT.

Print Name _____ Date _____

Sign Name _____ Witness _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice tells you about the ways Dr. Frank Shallenberger, MD may collect, store, and use and disclose your protected health information and your rights concerning your protected health information. "Protected Health Information" is information about you that can reasonably be used to identify you and that relates to your past, present, or future physical or mental health or condition, the provision of health care to you, or the payment for that care.

Federal and State laws require us to provide you with this Notice about your rights, our legal duties, and privacy practices with respect to your protected health information. We must follow the terms of this Notice while it is still in effect. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

Uses and Disclosures of Your Protected Health Information

We may use and disclose your protected health information for different purposes. The examples below are illustrations of the different types of uses and disclosures that we may make without obtaining your authorization.

- **Payment.** We may use and disclose your protected health information in order to pay for your covered health expenses. For example, we may use your protected health information to process claims or be reimbursed by another insurer that may be responsible for payment.

- **Treatment.** We may use and disclose your protected health information to assist your other health care providers in your diagnosis and treatment.

- **Health Care Operations.** We may use and disclose your protected health information in order to perform various operational activities.

- **Enrolled Dependents and Family Members.** We will mail explanation of benefits forms and other mailings containing protected health information to the address we have on record for you.

Other Permitted or Required Disclosures

- **As Required by Law.** We must disclose protected health information about you when required to do so by law.

- **Public Health Activities.** We may disclose your protected health information to public health agencies for reasons such as preventing or controlling disease, injury or disability.

- **Victims of Abuse, Neglect or Domestic Violence.** We may disclose your protected health information to government agencies about abuse, neglect or domestic violence.

- **Health Oversight Activities.** We may disclose protected health information to government oversight agencies (e.g. state insurance departments) for activities authorized by law.

NOTICE OF PRIVACY PRACTICES

- **Judicial and Administrative Proceedings.** We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about you in certain cases in response to a subpoena, discovery request or other lawful process.

- **Law Enforcement.** We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.

- **Coroners or Funeral Directors.** We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties.

- **Research.** Under certain circumstances, we may disclose protected health information about you for research purposes, provided certain measures have been taken to protect your privacy.

- **To Avert a Serious Threat to Health or Safety.** We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- **Special Government Functions.** We may disclose information as required by military authorities or to authorize Federal officials for national security and intelligence activities.

- **Workers' Compensation.** We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.

Other Uses or Disclosures with an Authorization
Other uses or disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed or if we are permitted by law to use the information to contest a claim or coverage under the Plan.

Your Rights Regarding your Protected Health Information
You may have certain rights regarding protected health information that Dr. Frank Shallenberger, MD maintains about you.

- **Right to Access Your Protected Health Information.** You have the right to review or obtain copies of your protected health information records, with some limited exceptions. Usually the records include billing, claims payment, and case or medical management records. Your request to review and/or obtain a copy of your protected health information must be made in writing. We may charge a fee for the costs of producing, copying, and mailing your requested information, but we will tell you the cost in advance.

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NOTICE OF PRIVACY PRACTICES

- **Right to an Accounting of Disclosures.** You have the right to request an accounting of disclosures we have made of your Protected Health Information. The list will not include our disclosures related to your treatment, our payment or health care operations, or disclosures made to you or with your authorization. The list may also exclude certain other disclosures, such as for national security purposes. Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than five years. Your request should indicate in what form you want the list (paper or electronically). For additional lists within the same time period, we may charge for providing the accounting, but we will tell you the cost in advance.

- **Right to Request Restrictions on the Use and Disclosure of Your Protected Health Information.** You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment or health care operations. ***We may not agree to your request.*** If we do agree, we will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information, or both; and (3) to whom you want the restrictions to apply.

- **Right to Receive Confidential Communications.** You have the right to request that we use a certain method to communicate with you or that we send information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice.** You have a right at any time to request a paper copy of this notice, even if you had previously agreed to receive an electronic copy.

- **Health Information Security**
  Dr. Frank Shallenberger, MD requires its employees to follow its security policies and procedures that limit access to health information about patients to those employees who need it to perform their job responsibilities. In addition, Dr. Frank Shallenberger, MD maintains physical, administrative and technical security measures to safeguard your protected health information.

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NOTICE OF PRIVACY PRACTICES

Changes to This Notice

We reserve the right to change the terms of this Notice at any time, effective for protected health information that we already have about you as well as any other information that we receive in the future. We will provide you with a copy of the new Notice whenever we make a material change to the privacy practices described in this Notice. Any time we make a material change to this Notice, we will promptly revise and issue the new Notice with the new effective date.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may file a complaint with us by contacting the office listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

We support your right to protect the privacy of your protected health information. ***We will not retaliate against you or penalize you for filing a complaint.***

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you have any questions or complaints, please contact:

The Nevada Center
1231 Country Club Drive
Carson City, NV 89703
(775)884-3990

I have read and understand the "Notice of Privacy Practices".

Signature_____

Date_____

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Appointment Policy

Cancellation Fees

1. I agree that in the case something arises and I need to reschedule an appointment for myself or a dependent, I will call at least 24 hours in advance to avoid a $50.00 failed appointment charge. No additional appointments will be scheduled until this fee has been paid.
   _____(initial)

2. I agree to be responsible for payments on behalf of myself or my dependents. I understand that payment is due at the time of service and no in-office financing is available. A $15.00 billing charge will be added to the amount due if not paid at the time of service._____(initial)

3. All phone consults are pre-paid and will be collected at the time you make the appointment._____(initial)

Signature_____
Date_____

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Informed Consent for Treatment

This document is a binding agreement (the "Agreement") between The Nevada Center ("Dr. Frank Shallenberger, MD") (MD defined as Medical Doctor) and the individual patient whose name and signature appears below ("You" "Your"). In consideration of the health care services which may be provided to you by Dr. Frank Shallenberger, MD, HMD, Jeff Hanson, NMD, APH and Alyssa Hahn, APRN 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):

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 Dr. Frank Shallenberger, MD, HMD, Jeff Hanson, NMD, APH or Alyssa Hahn, APRN to provide you with health care treatments which, depending on Your health conditions, may include one or more of the following procedures: Naturopathic Medicine, Intravenous Infusions, Intramuscular Injections, Hormonal Replacement Therapy, Herbal Medicine, Intra-Articular and Extra-Articular Injection Therapy, HCG Weight loss Diet Program, Dietary and Nutritional Consultation, Prolozone™, Platelet Rich Plasma Injections, Low Dose Antigen Therapy, and Chelation Therapy; together the "Treatments" administered by Dr. Frank Shallenberger, MD and his medical staff. You acknowledge that Dr. Frank Shallenberger, MD has not made any guarantees or promises as to the outcome or the safety and efficacy of the above listed treatments.**(Initials)** _____
2. **Experimental Nature of Treatments.** You acknowledge and agree that the treatments may consist in whole or part of experimental procedures and methods, in which no governmental (including the U.S. Food and Drug Administration), scientific or medical authority has confirmed the safety or efficacy thereof. You acknowledge that the safety and efficacy record of some of the Treatments are based only on empirical and anecdotal evidence, which only shows that the Treatments appear to be relatively safe and effective. Dr. Frank Shallenberger, MD has informed you that the Treatments may alter, address, or decrease your pain, symptoms, or complaints, but also may have no effect. **(Initials)** _____
3. **Intravenous Therapy, Prolozone™, Injection Therapy Risks, Side Effects, Complications.** Dr. Frank Shallenberger, MD hereby informs You that there are certain unavoidable risks and potential side effects and complications to the treatments, including; without limitation, swelling, severe pain, bleeding, dizziness, numbness, scarring, allergic reactions, itching, headaches, soreness, inflammation, bruising, phlebitis, vomiting, fainting, metabolic disturbances. Treatments may very rarely cause infection, injury to nerves, frozen shoulder. **(Initials)** _____
4. **Description of Treatments.** The exact procedure, as well as the recommended sequence of treatments, will be explained to you when Dr. Frank Shallenberger, MD actually administers the treatments. You acknowledge that any of the Treatments may involve insertion of needles into our your skin and veins and the injection of standardized formulas which may include various nutritional substances, hormones, homeopathic medicine, chelation agents, and FDA approved prescriptive medicines, local anesthetic (i.e. Procaine), concentrated sugar water (Dextrose), concentrates of your own blood (platelet rich plasma) and, on occasion, other substances which will be explained to You before injections. **(Initial)** _____
5. **Information You Provide The Nevada Center.** You have provided The Nevada Center with a complete list of all prescription and non-prescription medications (i.e. dietary supplements) you are currently taking. Also you will provide 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 agree to update The Nevada Center immediately should this list change. **(Initials)** _____

1231 Country Club Drive
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6. **Assumption of Risk.** You hereby, acknowledge that after having read carefully and understood fully the terms of this agreement, having adequate time to ask any questions about this agreement you are willing to assume any and all risks associated with the treatments, including without limitation those described in the 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 initialing and signing this agreement, you nevertheless acknowledge your willingness to assume such risks and that your consent to the treatments is willing, voluntary and informed. **(Initials)** _____
7. **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)** _____
8. **Miscellaneous.** You agree that this agreement constitutes the entire agreement between you and The Nevada Center 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 representative and assignees. In case any of the provisions of this agreement is held invalid or illegal, such provisions 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 Nevada without regard to any choice of law principal. **(Initials)** _____

By signing this Agreement, You indicate that you have read, understood and agree to its terms, you have received a copy of this Agreement, and that you are the patient, Guarantor, the patient's legal representative or legally authorized to sign this Agreement and accept its terms.

Patient Name (Print) _____ Legal Guardian Name _____

Signature _____ Signature _____

Date _____ Date _____

Medical Doctor Certification: I Dr. Frank Shallenberger, MD, certify that I have explained to the patient or authorized person the nature of the proposed treatments, the medically significant alternatives, and in "lay terms" the purpose, likelihood of success, benefits, and reasonably foreseeable risks, 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.

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Prolozone, PRP and Stem Cell Therapy Informed Consent

I,_____ have elected to have either Dr Frank Shallenberger, Dr Jeff Hanson, or Alyssa Hahn, APRN perform PRP (platelet rich plasma) therapy, Stem Cell therapy and/or Prolozone on an injured and painful region of my musculoskeletal system. I have responsibilities as recipient of these therapies to inform the physician provider of such treatment of contraindications or potential contraindications prior to undergoing this treatment. I furthermore understand that my participation in this treatment represents a "good faith" effort by the physician provider. As such, should harm come to me, and since I am freely partaking in this treatment, I will hold harmless the physician provider of this treatment. Plus, I understand that I am likewise biding my representatives, estates, successors and assigns hold harmless the physician provider of this treatment. I furthermore, have been advised and educated about the injection techniques of Prolozone therapy with and without PRP/Stem Cells. I understand that no warranty or guarantee has been made as a result of care. I have been given an opportunity to ask questions about my treatment, my condition, alternative forms of treatment, risks of non-treatment and of treatment.

I have been advised that Prolozone, PRP and Stem Cell therapy are used for two reasons. First, these treatments can reduce or eliminate pain. Secondly, they can repair and regenerate damaged tissues including ligaments, joints, tendons, bones, and cartilage.

Prolozone treatments require the injection of local anesthetic, vitamins, minerals, herbs anti-inflammatory medication, dextrose (sugar), and oxygen in the form of ozone. With PRP therapy the recipient's blood is spun down in a centrifuge, the platelets are separated out, and are then injected into the treated areas. The Stem Cells we inject come from umbilical cords and is injected into the treated areas. The most common result of treatment is a substantial and immediate decrease of pain and increase of function. However, in a few cases the procedures may initially increase my pain for on to three days. On rare occasions with PRP therapy there may be severe pain lasting for as long as a week.

I understand that many insurance companies have determined this treatment to be experimental due to lack of large research studies in the scientific literature and the insurance companies will not pay for this procedure. I understand that some or all aspects of the procedure may not be specifically FDA approved. I have been informed that the RISKS AND COMPLICATIONS of Prolozone, PRP and Stem Cell therapy are:

1. Immediate pain in the injection site
2. Increased pain lasting for up to two weeks
3. Fainting from the injection
4. Allergic reaction to the solution
5. Itching at the injection site
6. Infection from the injection
7. Dizziness or fainting
8. Headache from spinal injections
9. Temporary nerve paralysis in certain low back injections
10. There may be NO beneficial effect from the treatment
11. Pneumothorax (collapsed lung)
12. When injecting near the lungs

Recipient of Prolozone, PRP and/or Stem Cell therapy

Signature_____ Date_____
Printed Name_____
Witness_____Date_____

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Informed Consent Regarding Recommended Screening Procedures

The following procedures are recommended by the American Medical Association in order to detect certain diseases at an earlier and much more treatable stage:

PSA – An annual blood test for all men older than 50 to detect prostate cancer.

Mammography – Performed annually on all women older than 40 to detect breast cancer.

Colonoscopy – Performed on all persons every ten years starting at the age of 50 to detect colorectal cancer.

Rectal examination and occult blood screening – Performed annually on all persons older than 50 to detect rectal prostate cancer in men, and rectal cancer in men and women.

Pelvic examination and Pap test – Performed in women every three years starting 3 years after they begin having sexual intercourse, or when they reach age 21 (whichever comes first) to detect cervical, uterine, and ovarian cancer. Pap testing is not recommended in women age 65 to 70 who have had at least three normal Pap tests and no abnormal Pap tests in the past 10 years, although pelvic examination is recommended. Pelvic examination is not recommended in women who have had their uterus and ovaries surgically removed.

Breast examination – Performed annually on all women older than 40 to detect breast cancer.

Comprehensive patient evaluation – Performed annually on all persons older than 50, and every two years on those under 50 to detect cardiovascular disease, skin cancer and diabetes.

Dr. Shallenberger agrees with all of these recommendations except the annual mammography. All women should receive a copy of our breast cancer prevention instructions, as well as an informed consent regarding annual breast thermography.

All screening procedures mentioned above can be performed by The Nevada Center except the colonoscopy, which is performed by a gastroenterologist. We will give you a referral for this procedure.

By my signature below, I acknowledge that I have read the above, and that all my questions regarding these statements have been answered, and that if I am a woman I have received a copy of the breast cancer prevention instructions and an informed consent regarding annual breast thermography.

Signature_____Date_____/_____/_____

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Medicare Private Contract

This agreement is between Dr. Frank Shallenberger, M.D., H.M.D., whose principal place of business is 1231 Country Club Drive, Carson City, NV 89703, and

Medicare Beneficiary: _____
(Patient's Name)

Who resides at: _____

_____

and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balance Budget Act of 1997. The Physician has informed Beneficiary or his/her legal representative that Physician has opted out of the Medicare program effective on January 1, 2018 for a period of at least two years and is automatically renewed every two years. The physician is not excluded from participating in Medicare Part B under [1128] 1128, [1156] 1156, or [1892] 1892 of the Social Security Act.

Beneficiary or his/her legal representative agrees, understands and expressly acknowledges the following:

Please Initial each section below

_____ Beneficiary or his/her legal representative agrees not to submit a claim to Medicare or to ask the physician to submit a claim to Medicare.

_____ Beneficiary or his/her legal representative will not and cannot bill Medicare upon each visit.

_____ Beneficiary or his/her legal representative accepts full responsibility for payment of the physician's charge for all services furnished by the physician.

_____ Beneficiary or his/her legal representative understands that Medicare limits do not apply to what the physician may charge for items or services furnished by the physician.

_____ Beneficiary or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

_____ Beneficiary or his/her legal representative enters into this contract with the knowledge that he/she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and the beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.

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_____ Beneficiary or his/her legal representative understands that Medi-Gap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

_____ Beneficiary or his/her legal representative acknowledges that the beneficiary is not currently in an emergency or urgent health care situation.

_____ Beneficiary or his/her legal representative acknowledges that a copy of this contract has been made available to him/her.

Executed on: _____
Date

By: _____
Beneficiary or his/her legal representative /patient signature

And: _____
Dr. Frank Shallenberger, M.D., H.M.D.