NORTHWEST NEURO-CRANIAL MEDICINE, L.L.C.
Sky Valley Healing Arts
DR HILLARY LAMPERS, ND
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NEURO-CRANIAL RESTRUCTURING (NCR) INFORMED CONSENT FOR TREATMENT

Patient Name (printed) _____

This Informed Consent for NCR Treatment ("Informed Consent") confirms that I am aware of the effects of NCR, as well as potential risks associated with Neuro-Cranial Restructuring ("NCR") with Dr. Hillary Lampers, ND ("Dr. Hillary") at Northwest Neuro-Cranial Medicine, L.L.C. ("NWNCM, L.L.C."). Specifically, I am aware of and have received desired information to provide this Informed Consent to treatment and acknowledge and agree to the following, without limitation:

1. NCR is a treatment to optimize structure and as such is not a cure-all treatment. I understand that NCR may or may not offer permanent results and that other life circumstances, injuries, post-NCR events and/or lifestyle habits may adversely impact the positive benefits that may otherwise be achieved. I also agree that NWNCM, L.L.C. and Dr. Hillary have not and cannot make any guarantees regarding the success or results that I may experience after NCR treatments.

2. NCR does not replace healthy diet, appropriate exercise, sleep, a toxin-free/pollution-free lifestyle, biochemical therapies and/or body detoxification, which are all essential components of natural therapy and personal health.

3. I understand that NCR is, therefore, NOT the primary therapy for severe degenerative diseases, autoimmune diseases, systemic infections or cancer, and is contraindicated (not recommended) with acute fractures (or recent acute fractures). I have received a list of "Cautions" from NWNCM, L.L.C. and will fully disclose to NWNCM, L.L.C. whether any such Cautions exist now or at a later date. I further understand that certain prescriptions, such as Coumadin or any other prescribed, over-the-counter medication, (such as aspirin, Tylenol or Advil) and/or naturopathic substances and/or teas may thin my blood and/or elevate my propensity to bleed during and/or after any NCR treatment and agree to accurately report my usage of any such substances prior to each NCR treatment.

4. I understand that after any NCR treatment with balloon inflation, the balloon may stay inflated for a few seconds in the top of my throat and it will be quickly deflated and removed. It is also very remotely possible for the balloon to break and fly into my throat.

5. I understand that individual outcomes of NCR treatment vary with each NCR treatment. Although it is impossible to list every potential risk, complication or side effect after any NCR treatment I understand that I may experience any one or more of the following:

a. Fatigue.
b. Sore nose, sore throat and/or sore facial areas.
c. Increased nasal mucus drainage.
d. Temporary worsening of sinus symptoms.
e. Bloody nose.
f. Aching or traveling pains or sensations in my head.
g. "Spaciness" or disorientation.
h. Reactions similar to influenza or head cold for up to three days.
i. Body soreness for a few days, which may be different from my typical patterns and temporarily more severe than usual.
j. Excitement, nervousness or euphoria interfering with sleep.
k. Change in fit of dentures or bridgework and/or structural facial changes.
l. Other individual reactions are possible and are generally mild and self-limiting.

I understand that individual reactions may last from a period of hours to several days or weeks following NCR and that different reactions may occur after each NCR treatment. Although rare and unanticipated, based on my **Patient Intake Form,** I also understand and agree that substantially more serious medical or health-related

complications may occur after or be triggered by NCR treatments and/or my other health circumstances. These potentially severe health consequences may include, without limitation, stroke, cardiac arrest, bone or cartilage breakage, blindness, paralysis, allergic reactions, respiratory problems, incomplete pain control, nausea and vomiting, temporary or permanent nerve injury, damage to surrounding body tissue, blood clots, compromised or other serious medical complications. All of the above-described potentially medical complications are collectively referred to as "Medical Complications." I agree to immediately notify NWNCM, L.L.C. and Dr. Hillary of any and all Medical Complications, in writing, immediately after any NCR treatment and/or the onset of such symptoms. I understand that I must also seek immediate medical attention from my primary physician if I experience any Medical Complications and/or if the anticipated NCR reactions are more severe or last longer than anticipated.

6. I am also aware that I am in a temporarily fragile state for about a month after I receive any NCR treatment. This means that I may reverse the benefits of NCR treatment with illness, accidents, excessive stress and/or inappropriate activities.

a. I will try to avoid inappropriate activities that incorporate traumatic or unpredictable components, such as, jarring, hitting, shocking and/or excessively fatiguing my body.
b. I will restrict my activities even though I may have less pain and may want to be more active.
c. I will avoid massage, bone and muscle manipulation of all kinds for at least the month following any NCR treatment and will also attempt to avoid routine dentistry and similar situations that are potentially traumatic.
d. I will try to exercise mildly and regularly choosing bilaterally symmetrical activities to promote continuing the benefits initiated by NCR.
e. I agree to abide by all **NCR Care and After Treatment** instructions received from NWNCM, L.L.C. and agree to promptly submit any requested post-NCR procedure questionnaires that may be provided, from time to time, by NWNCM, L.L.C.
f. If applicable, I understand that most Medical Complications and side effects are rare and temporary; however, I understand that they cannot be completely eliminated. I also understand that potential Medical Complications could result in the need for additional medical or surgical treatments or procedures, hospitalizations, blood transfusions, drug treatments, interventions or very rarely, permanent disability or death; and, I expressly agree to assume all responsibility, costs and risks for and/or related to the same.

7. I have also been informed that NCR is a gradual cumulative therapy, requiring multiple NCR treatments for initially satisfactory results and improves with additional NCR treatments. I understand that it is important to complete the recommended course of NCR treatments to promote desired results. I have had ample opportunity to seek out independent medical advice prior to any requested NCR treatment and I agree to seek out independent medical advice, as desired, before any NCR treatment. I understand NCR treatments and its risks and potential benefits of NCR treatments and I feel comfortable with this information and I wish to pursue NCR treatment from NWNCM, L.L.C.

8. I confirm that I attended an NCR orientation at NWNCM, L.L.C. *prior* to NCR treatment and had a complete opportunity to ask questions and received answers to all of my questions to my full satisfaction *before* any NCR treatment. I feel comfortable with the information I have received as a client of NWNCM, L.L.C. and I have had an adequate opportunity to consult with my regular or treating physician prior to obtaining NCR treatment. I agree to immediately contact Dr. Hillary, in writing, with any concerns, questions or adverse symptoms both before and/or after any NCR treatment.

9. I previously completed a **Consent for Naturopathic Treatment** and a **Patient Intake Form** and fully and accurately completed each such form, as applicable, to the best of my abilities. To the best of my knowledge, I do not have any physical, mental or medical impairment or disability that might impact my well being or overall health as a direct, consequential or indirect result of my voluntary decision to seek NCR treatments. I represent and warrant to NWNCM, L.L.C. that I will immediately inform NWNCM, L.L.C. of any change in my medical condition and/or on my completed this Informed Consent form prior to or after any NCR treatment, as applicable. I understand that certain changes in my medical condition may require the premature termination or delay of agreed upon NCR treatment.

10. I agree to seek independent medical advice and consultation regarding any and all prescription medication from my regular treating or prescribing physician. I understand that NWNCM, L.L.C. and Dr. Hillary are not responsible to and cannot provide advice to modify physician-prescribed medications and that each patient is independently responsible to seek advice from his or her regular or treating physician regarding the same.

11. I have reviewed all NCR fees payable and have agreed to make prompt payment of the same. I understand that I am solely responsible for all charges at the time of service. I understand that finance charges will begin accruing on all delinquent accounts that are thirty (30) days past due at a rate of one percent (1%) per month. The undersigned agrees that excessively overdue accounts may be forwarded to an outside collection agency and agrees to reimburse all fees and costs incurred or generated as a result of these collection efforts. I also specifically consent to venue and jurisdiction in the County and State in which I receive any NCR treatments from NWNCM, L.L.C.

12. I understand that most insurance providers do not cover NCR treatments and agree to be fully responsible for all costs of NCR treatments and related costs incurred.

13. Records are kept of all NCR treatments provided. Applicable state and federal privacy laws protect the confidentiality of your medical information and grant patients the right to see your medical records. You may also request a copy of your medical information, subject to payment of applicable file copying costs. If you believe any information in your record is inaccurate, you may request its correction. Your medical information will not be disclosed to others unless you direct us to do so, in writing, or applicable laws or legal duress compel us to do so.

14. I understand that there are inherent risks and potential personal Medical Complications associated with NCR, including, without limitation, those described in this Agreement, and I expressly assume all such risks, known and unknown, direct or indirect, associated with any NCR treatment. Being of sound mind and body and competent to enter into this Agreement, I further irrevocably waive and release any and all personal injury, property and/or any other damage claims against Dr. Hillary, NWNCM, L.L.C. and/or their employees, agents, representatives, advisors, consultants, independent contractors, office sharing associates and/or owners (herein collectively "Agents") that may arise as a result of the requested NCR treatment, including, without limitation, any Medical Complications and/or any other personal damages arising out of this Agreement and/or the NCR treatments or related services described herein. I represent and warrant to NWNCM, L.L.C. that all information described herein and in any applicable **Patient Intake Form** and/or **Consent to Naturopathic Treatment Form,** are true and correct. I also agree to broadly and liberally indemnify, defend and hold harmless Dr. Lampers, NWNCM, L.L.C. and their Agents from any direct or indirect liability or damages arising out of this Agreement and/or the inaccuracy of any representation or warranty made herein or in my **Patient Intake Form** and/or **Consent to Naturopathic Treatment Form.** The undersigned also agrees that this Agreement shall be binding on the undersigned successors, heirs and assigns.

15. In the event of a conflict between this **Informed Consent Agreement, Consent to Naturopathic Treatment Form, Patient Intake Form** and/or any other information (verbal or otherwise) that I have received from or provided to Dr. Hillary, NWNCM, L.L.C. or any third party regarding NCR treatments rendered, the terms and provisions of this Informed Consent Agreement shall govern and prevail.

16. I request treatment from and give my permission and consent to receive NCR treatment from Dr. Hillary at NWNCM, L.L.C. and understand that I may *prospectively* withdraw such consent, in writing, by simultaneous notice to Dr. Hillary and NWNCM, L.L.C. at the above-described address.

I CONFIRM THAT I HAVE READ, UNDERSTOOD AND VOLUNTARILY CONSENTED TO THE ABOVE-DESCRIBED PROVISIONS, VOLUNTARILY REQUESTED NCR TREATMENTS, WILL ABIDE BY ALL NCR CARE DURING AND AFTER TREATMENT INFORMATION AND INSTRUCTIONS AND FOR MUTUAL AND ADEQUATE CONSIDERATION EXPRESSLY CONSENTED TO THE INDEMNIFICATION, RELEASE AND WAIVER PROVISIONS DESCRIBED ABOVE.

Dated this _____ day of _____, 20____.

_____
Patient's Signature

_____ _____
Patient's Legal Guardian's Signature (Required for Patients under 18)

Guardian's relationship to Patient