



**Aloha!** As your wellness coach and Doctor, I want express my congratulations for your choosing to make this appointment. I hope you feel a sense of peace about your decision, because vibrant health is central to a happy life. You deserve the health boost you are about to get!

Health is a very personal and sensitive issue for all of us. I appreciate your trust and confidence. I too struggle to make the best health choices. I know how hard it is to try and not see results, or perhaps experience painful side-effects. Please feel a sense of security, safety, and refreshed hope, because there are new natural and safe remedies that are proving to be highly effective. Not only that, in most cases they are fairly easy to implement.

My goal is to give you your health freedom so that you can have the lifestyle you want without being dependent on drugs.

Thank you for your business.

To your health,

A handwritten signature in black ink that reads "Dr. Steve Daugherty". The signature is written in a cursive style.

## Frequently Asked Questions:

### 1. How do you find us?

We have finally found an office space, we will be moved in and serving patients there starting on November 6, 2007. The address is 1192 West Sunset Blvd. St. George Utah 84770. The office is set back a little from the street so it is easy to miss. Turn west onto Sunset from Bluff from the **center lane** (the far left lane turns onto Valley View and the far right lane goes straight out to Ivins) Position yourself in the right lane as soon as you can. The office is only a half a mile from the light at Valley View. There will be a lumberyard on your right hand side. There is a large red and white sign that says DIXIE LUMBER upon seeing this sign get in the right hand turn lane and slow to turn. At the end of the chain link fence you make a Right hand turn. You can also turn into L&M furnishings our driveways connect. If you are coming from Santa Clara turn left into the driveway between L&M furniture and the lumberyard. Parking is limited but there are 2 handicap spaces if you drive down the entry and make a small left. If you drive straight back you will see our unit #8. If you have any questions please call 773-2520 and I will be there to help.

Patients that need treated at my home office in cases of **EMERGENCY** only and **WITH AN APPOINTMENT** can find my home at 3560 Price Hills Dr., St. George, UT 84790. Take I-15. Go East on Brigham Rd. Take your first right onto Hidden Valley Rd. Take your first left onto Price Hills Dr. My Home is on the Right hand side of the street. Please take the cobble-stone steps on the left of the house down to the back and enter through the sliding glass doors. (Use the front door if you need a chair rail)

### 2. What should I bring?

Please bring any medical records including lab work that might be related to your condition. Please send in your completed welcome packet **PRIOR** to your visit. In this manner, your visit will be quicker and more effective. Send your welcome packet via . Please also print a hard copy, incase its gets lost through E-mail.

- fax (888)880-8230,
- email to [innerwellness@gmail.com](mailto:innerwellness@gmail.com), or
- regular mail to  
Gentle Healing Center,  
Attn. Dr. Doughty,  
1192 West Sunset Blvd.  
St. George Utah 84770.

### 2. Does insurance cover the visit?

Our office does not work with insurance companies directly. This is a cash practice. We do encourage our patients to use Med-One Medical services to bill your insurance company for you. If your insurance pays, Med-One will make it happen for you for just \$10 per claim. Many insurance companies offer some reimbursement for prevention, but typically provide more reimbursement if you are already in a diseased state. Please contact Med-One directly for insurance related questions: (480)924-5416. Their fax is (480)609-3915. Attached is their contract.

### 3. What payment type is accepted?

This is a cash practice. We appreciate **personal checks**. **Credit cards** are also accepted. Payment is due on the day of the visit or service. There is a \$20 returned check fee.

#### 4. **How much should I should I budget?**

Many patients prefer the discount package which is \$125 per hour in 15 minute increments. We usually have 45 min. appointments. We set our prices at 10% below suggested retail for most supplements and labs. We will match any price from local health food stores.

#### 5. **Do you offer low-income discounts?**

We have several patients in the low income category who offer to exchange services. Usually, we can find a way to make a win-win agreement.

#### 6. **We welcome referrals.**

We appreciate referrals. We typically send two movie passes for new patients that you refer. The only way to grow a business like this is word of mouth. Thank you. Another way you can help us grow our business is by writing a testimonial. We keep a binder of testimonials. It helps others who are considering naturopathic medicine.

#### 7. **What is Dr. Doughty's background?**

Naturopathic medicine is a state-licensed profession. It carries with it most of the same education, rights and responsibilities of traditional medical doctors. It requires a 4-year medical degree and a year of residency. Dr. Doughty earned his PhD in Naturopathic Medicine from Southwest College of Naturopathic Medicine. He served his residency in "Endocrinology and Naturopathic Medicine" at Arizona Advanced Medicine under Dr. Konrad Kail, former AANP President. Dr. Doughty specializes in holistic treatments of mind and body using a combination of counseling and IV therapy with diet and lifestyle coaching.

#### 8. **What is your return policy?**

Any product in good condition can be returned within two weeks. Good condition means "seal not broken", nor baked in a hot car. Unsealed products may NOT be returned. In the event that a product or service causes no effect or an adverse affect, you are **still responsible** to pay for the product or service.

#### 9. **What if I miss my appointment?**

We have no fee for missing appointments. Please be considerate and cancel appointments at least 24 hours in advance so that we may offer that time slot to others who may be on the waiting list.

**DR. STEVE DOUGHTY, ND**  
*Confidential Patient Contact Information*

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

*Preferred method to contact?*

€ Home Phone (\_\_\_\_) \_\_\_\_\_

€ Cell Phone (\_\_\_\_) \_\_\_\_\_

Email address \_\_\_\_\_

Is it acceptable for us to contact you via e-mail? \_\_\_\_

Is it acceptable for us to leave messages on a voice mail or answering machine? \_\_\_\_

Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ ext. \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Work Phone(\_\_\_\_) \_\_\_\_\_ ext. \_\_\_\_\_

If a Dependent Child, Parent's Name \_\_\_\_\_ DOB \_\_\_\_\_

Contact in Case of Emergency \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Policy Number \_\_\_\_\_

Would you like Dr. Doughty to be your primary care physician? \_\_\_\_ If not, who is your primary care physician? \_\_\_\_\_ Phone ( \_\_\_\_ ) \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

**Dr. Steve Doughty, ND**  
Patient Health History

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Today's Date \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Date of last Menses \_\_\_\_\_ Are you or do you plan to be pregnant? \_\_\_\_\_

What are your primary reasons for coming here: \_\_\_\_\_

How long have you had this condition? What may have caused it to start? What makes it better or worse?

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List any previous diagnoses for this condition and any treatments, were they effective?

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What medications and dosages are you currently taking? What side-effects do they cause?

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What supplements or herbs are you currently taking?

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What allergies do you have to medications, supplements, foods, animals, or other substances: None €

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Please List any past surgeries, hospitalizations, or hormone therapy treatments: (include dates)

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Do you have a family history of any of the following diseases?

	Sibling	Mother	Father	Maternal GM	Maternal GF	Paternal GM	Paternal GF
Diabetes							
Cancer							
Heart Disease							
Stroke							
Other							

Have you been exposed to pesticides, heavy metals, metal fillings, cigarette smoking or other toxic chemicals?  
Or are you chemically sensitive?

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Have you gotten sick during or soon after camping trips or traveling outside the US?

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Have you been involved in activities which put you at risk for HIV? Would you like to be tested?

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Have you ever had suicidal thoughts? Have you ever had a problem with drug or sexual abuse, or eating disorders? Could these be related to your current issue?

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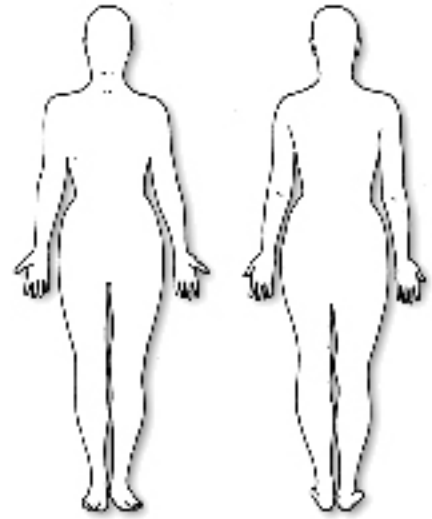
Are you experiencing pain in your body?  
( Put an X over areas of pain.)

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Describe your sleeping habits. ( Work nights? What time do you go to bed? wake up? can you fall asleep easily? How often do you wake at night and why? Can you easily get back to sleep? Do you feel refreshed in the morning?)

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Describe your typical diet. ( Include the typical time the meal is consumed also. Also include snacks.

Breakfast

Lunch

Dinner

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<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

Estimate number of servings in each category:

Grains \_\_\_\_ Vegetables \_\_\_\_ Fruit \_\_\_\_ Fish or Soy \_\_\_\_ Bleached and Processed \_\_\_\_ Meat/Dairy \_\_\_\_

Sugar \_\_\_\_ Salt \_\_\_\_

Form of drink: Water (oz / day) \_\_\_\_\_ Juice \_\_\_\_\_ Soda \_\_\_\_\_ Caffeine \_\_\_\_ Alcohol \_\_\_\_

What time do you eat your last snack of the day? \_\_\_\_\_

Describe your typical exercise (aerobic, stretching, weight baring), times per week, duration?

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Are you in direct or indirect sunlight 30 min. each day? \_\_\_\_\_

**Review of Systems: ( Circle the following problems that you may be experiencing?)**

- |  |                                    |   |
|--|------------------------------------|---|
| 1. Difficulty falling asleep.          | 20. Sugar cravings / hypoglycemia  | 40. Stroke                              |
| 2. Difficulty staying asleep.          | 21. Nightmares                     | 41. Cardiac disease                     |
| 3. Elevated inflammation / CRP         | 22. Diabetes                       | 42. Hypertension                        |
| 4. Need naps & feel fatigued           | 23. Weight gain                    | 43. Athlerosclerosis                    |
| 5. Light-headed when standing.         | 24. Chemical intolerance           | 44. Chest pain                          |
| 6. Night sweats                        | 25. Headaches                      | 45. Shortness of breath                 |
| 7. Temperature below 97.8              | 26. Cancer or abnormal pap.        | 46. Hyperlipidemia                      |
| 8. Side effects of anti-depressants.   | 27. Hepatitis, TB                  | 47. Difficulty breathing                |
| 9. Poorer Memory                       | 28. Alcohol usage                  | 48. Asthma                              |
| 10. Anxiety attacks                    | 29. Neurological decrease or pain. | 49. Seasonal allergies / flu-like       |
| 11. Frequent Anger or Irritability     | 30. Salt cravings                  | 50. Edema of joints                     |
| 12. Indigestion                        | 31. Excess thirst                  | 51. Joint pain or arthritis             |
| 13. Constipation                       | 32. Gallstones or kidney stones    | 52. Steroids or pain killers            |
| 14. Gas and bloating                   | 33. Kidney disease                 | 53. Poor immune system                  |
| 15. Abdominal pain or tenderness       | 34. Birth control pills            | 54. Autoimmune disease                  |
| 16. Eczema, fungal, or skin conditions | 35. Irregular or heavy menses      | 55. Hair loss (body, scalp, or temples) |
| 17. Loose stools                       | 36. Hot flashes                    | 56. Difficulty urinating or leakage.    |
| 18. Blood in stool                     | 37. Loss of height/bone density    | 57. Anemia                              |
| 19. Crohn's or Inflammatory Bowel      | 38. Premenstrual syndrome          | 58. Mood swings                         |
|  | 39. Poor libido or sexual problems | Other : _____                           |

**Do you have any special requests, health questions, goals, or anything individualized we can do for you?**

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# DR. STEVE DOUGHTY, ND

640 E. 700 S. #10C  
St. George, UT 84770

## AGREEMENT TO PARTICIPATE IN RESEARCH

### Electrodermal Screening and Measurement

Participant's Name \_\_\_\_\_ Number \_\_\_\_\_

Doctor's Name : Dr. Steve Doughty Date \_\_\_\_\_

Electrodermal screening measures the conductance of electricity (energy) through specific acupuncture points located on the hands and feet. A computerized recording device, the Computronix System, uses software to collect information about the functional, energetic status of the body based on reference point measurements. This "new device" technology is considered investigational and to be used at this time for research purposes.

Screening sessions last for 20 minutes to an hour, depending on how many points are measured. Skin measurement is obtained with a metallic probe applied to areas of high conductivity (acupuncture points). Pressure is applied and a small amount of current, 6-12 micro amps, enters through the skin. A recording is then taken on the response of the meridian (energy pathway) to these micro currents. There may be discomfort at some areas of testing for some individuals, depending on variances in stresses and pain thresholds. Skin irritation or redness may occur at the electrode placement sites.

Confidentiality regarding all test results is strictly adhered to with identification numbers, not name, used for any identification purposes. Participants may voluntarily withdraw from the study at any time. The benefits to humanity from participation include gaining a better understanding of energetic diagnosis and treatment, based on an international, multidisciplinary perspective.

Although the chance of adverse effects are small, I understand that if I am injured in the course of this research procedure, that I, alone, may be responsible for the costs of treating my injuries. I understand that I may be responsible for the costs of tests, procedures or medications that are solely part of the research project.

I certify that I have been told of the possible risks involved in this project, that I have been given satisfactory answers to my inquiries concerning project procedures and other matters and that I have been advised that I am free to withdraw my consent and to discontinue participation at any time without prejudice.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

If you have any questions, comments or concerns, you may contact:  
Dr. Konrad Kail, Principal Investigator at (602) 493-2273,  
Dr. Steve Doughty, investigator at (888)338-4541,  
or Jim Jose, Research Monitor at (310) 394-6497.

MED-ONE MEDICAL SERVICES  
5112 E. DECATUR STREET  
MESA, AZ 85205

Dear Patients,

We are currently working with many patients throughout the US. helping them recover fees paid for medical care. We come to you highly qualified with over 19 years of successful billing and collection of medical claims for doctors, hospitals, and patients.

**What we will do for you:**

1. We will call the insurance company to verify your benefits. Do not call and try to explain treatment to the insurance company, let us handle this for you. We will call you back with this information before any billing commences.
2. We will present your bills to the Insurance carrier in the proper format for reimbursement. You need to allow 30 days for reimbursement. Legally the Insurance has between 30/45 days before they have to process any claim.
3. We will do everything possible to collect your money from the insurance company.
4. We have been doing IPT and IV Infusion billing for 8 years.

Information that we will need from you:

- a. Your full name as it appears on your insurance card, complete address, telephone numbers, date of birth and social security number.
- b. The ID number and group number as it appears on the insurance card.
- c. Name of insurance company, their telephone number, and claims address.
- d. Invoices and drug sheets that the doctors office gives you.
- e. Once we start billing, we will need you to be prompt with sending a copy of all items you receive back from the insurance company. **WE DO NOT RECEIVE ANY ITEMS FROM THE INSURANCE COMPANY, SO YOU ARE OUR ONLY CONTACT.**

If you fax your Insurance information, be sure that it is hand written clearly in ink. Office hours are 9:00 AM to 5:00 PM mountain standard. All questions need to be directed to: 480-924-5416, or faxed anytime to: 480-985-3264, we will return your call within 24 hours.

**CHARGES:** We will bill you approximately every two weeks for claims submitted. The charge for each date of service is \$10.00. A claim constitutes everything that is done on that day of service, there will be no other charges for future work on those particular dates if it should be required. We do expect you to send payment to us upon receipt of the Invoice. not when you receive your payment. Checks are to be made payable to Shawn Hines, and mailed to the address above.

If you are interested in having out company handle your insurance billings, call. If we are out of the office, please leave your name and number, we will return your call promptly. Thank you

Sincerely,  
Shawn Hines  
Sharon Hines

## LEGAL CONTRACT/INDEMNITY/HOLD HARMLESS

This is to serve as a legal contract between MED-ONE Medical Services a.k.a. SSL Hines Corp./ S. Hines and this Patient.

MED-ONE Medical Services is doing work strictly for the patient and is not affiliated with any provider or medical clinic. This is a stand alone corporation owned solely by SSL Hines Corp.

This contract allows MED-ONE and its Employees to contact any/all insurance companies this patient is involved with, to acquire information regarding benefits and claims.

This contract allows MED-ONE and its Employees to request and receive any information requested by your Insurance company to get a claim paid.

This contract serves as a medical release for this information to be released to MED-ONE when requesting it for the purpose of collecting medical bills.

Patient and/or Family agree to pay all the required fees for these services. Regardless of any Insurance Companies determination of benefits, there are no guarantee of payment until the insurance company processes the claim.

This company is HIIPPA Compliance. Any information released to MED-ONE or its employees will be kept strictly confidential according to HIPPA rules.

Indemnity/Hold Harnless. Patient/Spouse/guardian specifically agrees to indemnify, defend and hold harmless Med-One, Patient Provider/Doctor and their successors, from and against any and all federal and state income taxes, FICA (social security) taxes, withholdings, claims, liens, actions, suits, proceedings, costs, expense, damages and liabilities, including reasonable attorneys' fees arising directly or indirectly from or out of, connected with, or resulting from the performance by/or under this Agreement. Neither final payment by, nor acceptance of the services hereunder shall constitute a waiver of this indemnity.

Patient Signature		Date
Spouse or Gardian Signature		Date
Med-One Authorized Signature		Date