NON-CONVENTIONAL TREATMENT

Consent Form

I, _____, herby authorize the following procedure: _____ treatment (s), a treatment for _____.
I understand that the procedure will involve

_____

_____,
possibly combined with diet and lifestyle modifications.

I understand that the above mentioned therapy (s) is not a currently medically accepted procedure for testing or treating my above mentioned illness or concern and, thus, that its use for this purpose may be considered by some insurance companies to be "medically unnecessary" or "experimental". The procedure has some risks. Dr Pryce/Dr Scheerer has explained to me verbally the short and long term risks, which may include temporary worsening of my current symptoms or headache, tachycardia (increased heart rate), syncope (fainting), visual difficulties, shortness of breath, joint pains, red eyes, itchy eyes, nasal congestion, numbness, gastrointestinal disturbances and a very rare but serious reaction called anaphylaxis. Also, further side-effects or complications could occur.

By signing this form, I accept those risks. Moreover, I understand and accept that because this procedure may be considered "medically unnecessary" or "experimental", it may not mitigate, alleviate, or cure my condition (s). Its possible benefits may not be apparent immediately . The possible benefits include mitigation or improvement of my current symptoms, improvement of respiratory function, decreased skin reactions, increased stamina, improved metabolism, decrease in frequency or severity of headaches, improved concentration, and others.

I understand the nature of the treatment, which has been explained to me by Dr Pryce/Dr Scheerer.

I understand that the currently "standard" medically indicated treatment (s) for my condition is/are

_____

_____

_____

I understand that the risks of those treatments include: no improvement or worsening of my condition; headache, tachycardia (increased heart rate), syncope (fainting), visual difficulties, shortness of breath, joint pains, red eyes, itchy eyes, nasal congestion,

numbness, gastrointestinal disturbances and a very rare but serious reaction called anaphylaxis and others.

Based on the risks and potential benefits of the currently medically indicated treatment (s) and of proposed treatment, I have elected to forego or supplement the indicated treatment(s) and receive the proposed treatment from Dr Pryce/Dr Scheerer.

I further understand and agree to adhere to the treatment schedule and attend the follow-up visitations set by Dr Pryce/Scheerer to permit observation and study of my progress. I also agree to comply with the recommended lifestyle modifications in order to provide optimum opportunities for beneficial effects.

I understand that I may suspend or terminate my treatment at anytime by informing Dr Pryce/Scheerer.

I assume full liability for any adverse effects that may result from the non-negligent administration of the proposed treatment. I waive any claim in law or equity for redress of any grievance that I may have concerning or resulting from the procedure, except as that claim pertains to negligent administration of this procedure.

I hereby confirm that the nature and purpose of the aforementioned treatment may be considered medically unnecessary or experimental and not currently indicated treatments. The risks involved and the possibilities of complications have been explained to me. I fully understand that the treatment to be provided may be considered experimental and unproven by scientific testing and peer-reviewed publication.

Signature of Patient _____ Date:_____

Signature of Witness _____ Time:_____

*** Additional Consent for IV therapy**

_____ Parenteral therapy with nutrients is not yet considered to be "traditional" therapy in this country. More and more physicians are finding the benefits from this approach, but it will take quite some time before it is considered the "standard" of care. For this reason—because it is a non traditional approach – Holistic Family Practice, Balanced Integration, LLC, Dr's Pryce and Scheerer want you to understand the risk verses benefit ratio of this important approach to helping solve your health problems.

_____IV therapy with nutrients must be considered "investigational" in this country and *does not benefit all patients.* Some of the IV nutrients in the form or dosage used by this office are not yet approved by the FDA. If you have a serious illness, *IV therapy could even make you considerably worse after the first (or even the first few) treatment (s),* so you must be aware of this eventuality. We generally ask our patients to commit to 3 treatments at a minimum, as it sometimes takes 3 treatments to see a significant effect. However, if satisfactory subjective or clinical results are not noted by the time the first 3 treatments are complete, we generally discontinue therapy and move on to another approach.

_____ IV therapy is generally administered once or even twice weekly until you are able to go longer between treatments without loss of benefit. Generally speaking, should you note an improvement with IV therapy, you should find that the periods of improvement last longer and longer as time goes on. IV therapy with nutrients is often combined with other treatment modalities in this office, and it is hoped and somewhat expected that IV therapy can be discontinued without loss of benefit when the other treatment modalities take effect.

_____ The general risks of IV therapy include, with decreasing frequency: worsening of symptoms after the first 1-3 treatments (lessening with each, if it happens); failure to achieve a substantial benefit; discomfort during the infusion; irritation of the vein, causing eventual closure of the vein; inflammation at the site of an IV (phlebitis));death. All except the first 3 are extremely rare, and there has never been a reported death from IV therapy with any of the nutrients used in our office (I include it here because it must be included in any disclaimer form).

_____ By signing this form, you acknowledge that you understand all of the above information, and that you are consenting to parenteral therapy with such knowledge.

Signature of Patient _____ Date:_____

Signature of Witness _____ Time:_____