CARDEA HEALTH
integrative

CHELATION THERAPY CONSENT FORM

I, _____, hereby give consent to Cardea Health Integrative to perform intravenous EDTA Chelation Therapy for the purpose of treatment of atherosclerotic disease and/or heavy metal toxicity, and/or prevention or treatment of degenerative diseases. I understand that Chelation Therapy is a standard therapy widely approved for the treatment of heavy metal toxicity; however, its usage is considered controversial for the generalized treatment of atherosclerotic vascular disease and other degenerative disease. The view that it is of benefit in the treatment of such disorders is accepted by a minority of the medical community and it is considered "experimental" by most physicians. I am advised that my treating physician believes that Chelation Therapy does have positive clinical benefit. I have been informed that other treatment approaches have been used in these conditions, including but not limited to bypass surgery or angioplasty and these alternatives have been explained to me to my full satisfaction.

I understand that the benefits of Chelation Therapy are much greater if I follow a healthy lifestyle, ie.: non-smoking, weight control, proper exercise, proper diet, and nutritional supplements. I understand that an initial series of ____ treatments is anticipated and these treatments may be extended over a number of months. I have been informed that Chelation Therapy may need to be repeated from time to time in the future in order to maintain the benefit. I understand that it is my option to stop this treatment protocol at any time without incurring any further expense after I have directed that such treatment be stopped.

I have been informed of possible risks and side effects including but not limited to discomfort at the injection site, thrombophlebitis (inflammation of a vein associated with thrombus formation), hypocalcemia (reduction of the blood calcium below normal), fatigue, muscle cramps, transient dizziness, kidney problems including nephrotoxicity (being toxic or destructive to kidney cells), allergic reaction, congestive heart failure, anticoagulation, lowering of blood sugar levels and/or hypoglycemia, mineral loss, liver disease, although rare and generalized complaints. If I have suffered from any previous kidney disease, I agree to execute a medical release so that all previously identified medical records of mine may be obtained from previous treating physicians, and I have disclosed openly any know previous kidney disorders. I understand that this therapy should not be used if I am pregnant unless I have a severe life-threatening disease. I understand that if I have a history of tuberculosis, Chelation Therapy may reactivate arrested tuberculosis and I agree to inform any physician of any occurrence of this disease. I understand the nature of the proposed procedure and the risks and dangers have been explained to me to my full satisfaction. I have not been asked to discontinue care with any specialists.

While I understand that there have been no warranties, assurances or guarantees of successful treatment made to me, I desire to undergo this treatment after having considered the information contained in this document, the information provided to me through my conversations with my treating physician and through materials provided to me by the office to educate me about the treatment. I acknowledge that I have had the opportunity to ask any questions of the physician with respect to the proposed therapy and the procedure to be utilized and all of my questions have been answered to my full satisfaction.

I HAVE READ AND UNDERSTAND THE ABOVE. Under the conditions indicated, I hereby place myself under care for Chelation Therapy, and agree to the above release.

Date:_____ Patient Signature:_____