

CHELATION THERAPY CONSENT FORM

The method of administration of disodium edetate (EDTA), the purpose for its administration in your case; its potential for good and its potential for harmful side effects has been fully explained to you; and you have indicated a desire to undertake this procedure in your case. It is now our purpose to stipulate our full and complete understanding with reference to such therapy, and to place a limitation upon our legal liability in the event it is unsuccessful.

You have been advised by us that ETA has been cleared by the Food and Drug Administration for mobilization and reduction of heavy metals (such as lead) from the body where undesirable quantities are present; that, in addition, EDTA is being used increasingly by a minority of physicians for treatment of arteriosclerosis and related conditions; and that this latter usage has been disapproved by the medical association and/or other groups on the grounds that this substance has not yet been shown to be "safe" or "effective" or "usual, customary and reasonable." Because of such disapproval, and because a majority of doctors do not use it, insurance companies ordinarily refuse to pay for EDTA therapy.

Whether or not Chelation Therapy is "safe" or "effective" for a specific condition depends upon the degree of likelihood of injury from the use of the procedure when properly administered, upon the prognosis for the condition if left untreated, and upon your cooperation in following the dietary and rest regimen which accompanies the procedure, it is believed in your case Chelation Therapy is proper under these criteria, and you will quite probably improve in the condition for which you are under treatment, and in your overall health, from its use. However, you must understand no one can or does guarantee or warrant the results in any manner. Further, because the use of EDTA is regarded as experimental for the reasons previously cited, we cannot and do not offer this procedure to you except upon the condition you do release us from any legal responsibility for harm resulting from its use in your case, and your signature on this agreement will constitute a full and final release of our legal responsibility resulting from the administration of Chelation Therapy in your case and/or any other medical treatment which may be necessary as a result thereof.

Douglas B. Cook DC

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. This also signifies I have been given a patient handbook on Chelation Therapy which I have read carefully and understand the contents. I also give my consent that all photographic materials, tissue, urine or blood specimens taken of me or from me may be displayed, distributed, published and otherwise used for educational and teaching purposes as long as my identity remains anonymous.

DATED _____
Patient

WITNESS: _____