IV Chelation Therapy Consent Form

I hereby give consent to Dr. _________________________ to perform intravenous Calcium EDTA chelation therapy for the purpose of treatment of atherosclerotic disease and/or heavy metal toxicity and/or the prevention or treatment of degenerative diseases. I understand that Chelation Therapy is a standard therapy 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 diseases, and the view that it is of benefit in the treatment of such disorders is accepted by a minority of the medical community, and is considered "experimental" by most physicians and insurance companies. I am advised 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 (non-smoking, weight control, proper exercise, proper diet, and nutritional supplementation). I understand that an initial series of _____ treatments are anticipated, and that 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 benefits. I understand that it is my option to stop this treatment protocol at any time without incurring any further expense after I have decided that such treatment be discontinued.

I have been informed of possible risks and side effects including but not limited to: discomfort at the injection site, thrombophlebitis, fatigue, muscle cramps, allergic reaction, kidney problems, liver problems, lowering of blood sugar levels and/or hypoglycemia, mineral loss, and generalized complaints.

If I have suffered from 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 known previous kidney disorder. I understand that this therapy should not be used if I am pregnant. I understand that if I have a history of tuberulosis, Chelation Therapy may reactivate arrested tuberculosis and I agree to inform my 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 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 my physician with respect to the proposed therapy, and the procedures to be utilized, and all of my questions have been answered to my full satisfaction. I also acknowledge that I have received a copy of this signed, informed consent.

I understand that Medicare does not pay for chelation therapy with EDTA for vascular disease, and may not pay for laboratory testing after chelation therapy has been administered. I also understand that there are very few commercial insurance companies that will pay for chelation therapy with EDTA.

Date: ______________________________

Patient Signature: ____

Witness: ____