Tequesta Family Practice

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R. J. Oenbrink, DO

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Informed Consent Form

I, Testyapatient, Testyapatient do hereby give consent to *Tequesta Family Practice* and specifically to Dr. Oenbrink to perform therapy for the purpose of treatment of conditions that I have reviewed with the medical staff of Tequesta Family Practice. I understand that this therapy is considered controversial by some and is intended to be used as a complementary treatment, not designed to replace more traditional therapies. I am advised that my treating physician believes that this therapy does have positive clinical benefit.

I understand that the benefits of this 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 weeks to months. I have been informed that this 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 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, infection, inflammation, hives/rash, thrombophlebitis, hypocalcemia, fatigue, muscle cramps, kidney problems including nephrotoxicity, allergic reaction, congestive heart failure, liver disease, anticoagulation, lowering of blood sugar levels and/or hypoglycemia, mineral loss 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 known previous kidney disorders. I understand that during pregnancy this therapy may have unanticipated consequences to the fetus and should not be used if I am pregnant unless I have a severe life-threatening 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 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 and most insurance companies do not pay for this therapy, and may not pay for laboratory testing after therapy has been instituted.

Date: 01/16/2011 10:52

Patient's Signature_____

Patient's Name: Testyapatient, Testyapatient

Witness :_____