Informed Consent Agreement

NMT: The Feinberg Method Local and Remote Session Consent Form

I understand that NeuroModulation Technique ("NMT") is intended to determine the patient's mind-body perceptions of internal conditions that may be contributing to illness behaviors and to attempt to establish perceptions that may be more conducive to health. I understand that NMT that is conducted either on a local in-office or a remote basis in which I do not attend the practitioner's office and further stipulate that I understand that the remote NMT session is not considered to be a medical treatment, or therapy of any kind. I understand that the remote NMT session is considered a telephone consultation and that this is the service which I hereby request and for which I am being charged and will pay for. I am requesting local and/or remote NMT sessions from _____located at:_____. Remote sessions may be conducted via telephone when I am unable or do not wish to physically visit his clinic. Specifically, I understand that these NMT sessions are informational in nature and not in any way to be considered chiropractic, acupuncture, or medical treatments of any kind.

I understand that under no circumstances is it appropriate to bill my medical insurance for any remote NMT sessions and agree that I will not submit such bills to my insurance. Further, I understand that remote and in-office NMT sessions may be considered investigational and may not be paid by my health or other insurance.

The NMT procedure has been explained to me, and I understand that certain adverse effects may be associated with local or remote NMT sessions that could include, but are not limited to, a temporary flare-up of my symptoms. Other possible side effects include symptoms of heightened immune function or detoxification such as fever, chills, headache or body aches. I understand, and agree, that if any unexpected exacerbation of my symptoms should occur, if any medical emergency should occur, that I am solely responsible for obtaining appropriate medical care to address those symptoms or conditions, and will do so in a timely manner.

I understand that medical diagnosis requires particular types of clinical examination procedures by a physician trained in diagnosis and that NMT: The Feinberg Method is not a medical diagnostic procedure, does not diagnose any disease, and that NMT evaluation procedures are not a substitute for physical examination, laboratory testing, medical imaging or other diagnostic procedures. By contrast, NMT is intended to determine the patient's mind-body perception of conditions that may be contributing to illness. I understand that Muscle Response Testing, ("MRT") employed in NMT is not 100% accurate and is only an indication of patient perceptions and not an objective measure of body conditions. I understand that my local or remote NMT sessions may utilize surrogate muscle response testing in which muscle response from the NMT practitioner or other third party is used as an indicator of response to the semantic queries and statements the practitioner verbally delivers to me. I understand that local or remote NMT sessions should be considered investigational or experimental and that the efficacy of such services has not been established in published scientific literature.

I understand that alternative methods of treatment are available and have been described to me. If I am suffering from severe allergic reactions to food or other substances, or any health condition for which I have been prescribed medications to control dangerous symptoms, I will consult an

*Please initial after reading this page*_____

appropriate physician and, if so advised, take medication (to prevent itching, tissue swelling, fever, cough, pains, etc.) to keep my symptoms under control while I am receiving remote NMT sessions.

I understand that determination of the existence and identification of particular infectious agents or cancer in the body requires specific medical laboratory testing. NMT: The Feinberg Technique does not diagnose any infectious agent, or cancer, nor is it a substitute for appropriate laboratory testing. Rather, NMT evaluates the patient's mind-body perceptions with regard to such issues and attempts to direct a more effective immune system response by changing mind-body self awareness.

NMT: The Feinberg Technique is not a method of diagnosing or treating cancer. Medical oncologists are the only health care personnel appropriately trained to manage the treatment of cancer. NMT is not a substitute for appropriate medical care of cancer, or any other health care condition. I understand that I am not being asked to discontinue any concurrent medical care. Moreover, I understand that it is recommended that I do not discontinue any care prescribed by my doctors.

I agree to cooperate and take an active role while receiving remote NMT sessions by maintaining a positive attitude toward healing, continuing contact with and treatment from my other medical practitioners, and communicating progress and any possible side effects or new symptoms that may or may not be related to my NMT session to my NMT practitioner. I understand that I am to continue all medication and other treatment modalities as they have been prescribed unless otherwise directed by the doctor who prescribed them. I also understand that improvement in my health resulting from the NMT treatment I am requesting, may result in a change in my requirement for medications other providers have prescribed for me, and will consult that medical provider to see if a change in medication or medication dosage is necessary.

I understand that there is no guarantee concerning the effects of the treatment. I understand that I am free to discontinue NMT sessions at any time, but acknowledge that I am responsible for full payment of the normal and necessary fees associated with my NMT sessions. I understand that if I terminate treatment without the recommendation of my NMT practitioner, that this may adversely influence the degree or durability of my improvement. I agree that if I have allergies causing dangerous symptoms such as anaphylactic response, or any condition that is aggravated by certain activities or exposures, that I will not expose myself to such risk of aggravation except as advised by my NMT practitioner under controlled and defined circumstances. I understand that if I expose myself to such aggravating factors prematurely, this may pose a risk to my health.

I understand that any services that are being provided on a local or remote basis are my sole financial responsibility, and that no aspect of such services may be billed to insurance companies for the purposes of reimbursement. I understand and authorize all charges for this service to be

billed to the credit card account I have provided or that such services will be paid by the time the service is provided by other means. I understand that these charges will be billed under the name:_____ at the rate of:_____. I understand and agree that office policy requires 24 hour notice to cancel a previously scheduled appointment and I will be charged the full fee for such appointments canceled without 24 hour notice.

I further agree to be interviewed during this teleconference, and that this interview and my voice may be audiotaped. I understand that these recorded audiotapes may be used for telephone

*Please initial after reading this page*_____

consultation evaluation, research, and NMT training purposes only, at both the transmitting and receiving or other facilities, and that my identity will not be disclosed except where medically necessary or by my permission. I understand that without prior written consent, said recorded tapes will not be broadcast or otherwise played outside the health care or educational setting.

I understand that the NMT session results in the selection of portions of the NMT protocol that the NMT practitioner finds appropriate for me and that this information is communicated to my mind-body by way of intention. I further understand that if the NMT Scalar Treeview system is used in my NMT care that this computerized system will simply assemble this information that has comprised my NMT session in the form of an mp3 or other format audio data file. That data file may be provided to me for the purpose of playing on a media player using a special scalar antenna. The purpose of this use of the audio data file is modulate the scalar field produced by use of the file with the scalar antenna in such a way as to create a scalar representation of that NMT session information. I understand that the scalar field has no known medical effect and that the purpose of using this scalar output of the audio data file is based on the unproven possibility that this scalar representation of the data from my NMT sessions might be perceivable by my mind-body and if so, might thereby reinforce any informational training effect that such NMT sessions may have. I also understand that if I perceive any adverse effect that I associate with the use of this scalar playback that I will immediately stop using it and notify my NMT practitioner.

I also understand that clinical data is presently being collected on the NMT method that requires the gathering of certain information in accordance with research protocols. I understand that the results of this study may be published in a medical or scientific journal and that a number or letter designating my case, but not my name, may be used in reports of this study and hereby give my permission for the use of such information.

I have read, or have had read to me, the above statements, and have been provided with the opportunity to ask any pertinent questions I have regarding this NMT screening and treatment program. I have been informed that I am to contact the doctor if any problems are encountered during or after my NMT sessions and agree to do so. I understand the conditions stated above, and hereby consent to participate in these local and/or remote NMT sessions. By signing below I agree to the terms, procedures, and permissions set forth above.

IN WITNESS WHEREOF, I have executed the foregoing this _____day of _____, _____.

_____ _____

Patient's Signature *Patient's Printed Name*

_____ _____

If minor, signature of parent or guardian *Parent or Guardian's Printed Name*