20 Cedar Boulevard, Suite 303 Phone: 412-563-1600
Mt. Lebanon, PA 15228 Fax: 412-563-2040
www.PittsburghAlternativeHealth.com

INFORMED CONSENT AGREEMENT FOR SENSITIVITY ASSESSMENT

Patient Name:_____ Telephone: (____)_____
Address:_____
City: _____Zip Code:_____

I desire to be assessed to determine possible undesirable reactions to various substances that are natural constituents of my diet, environment or body chemistry. I understand that the assessment procedure to be used is not generally employed by the majority of physicians for this purpose.

I choose to be assessed using an electro-dermal technique via a Biomeridian® testing device. I also understand that electro-dermal assessment has not been scientifically proven to be reliable, and that my physician must still rely upon personal observations and history as to the efficacy of the assessment and balancing technique.

I understand that other methods of sensitivity assessment are available and these have been described to me.

I understand that I may decline to participate in the electro-dermal assessment and can choose instead to have other sensitivity assessments with my own personal physician.

I am not on this visit or any subsequent visit as an agent for federal, state, or local agencies, or on a mission of entrapment or investigation.

I have been provided with the opportunity to ask any pertinent questions I have regarding this assessment and balancing technique.

I understand that the Pennsylvania Medical Association does not currently find demonstrated scientific basis for this assessment technique, and this test therefore is not recognized as reimbursable by any insurance company.

I understand that I am responsible for payment of the normal and necessary fees associated with my assessment and balancing.

IN WITNESS WHEROF, I have executed the foregoing this ____ day of _____, 201__.
Name (please print):_____

Signed:_____ Date: _____
if under 18 years of age, Parent or Guardian must also sign)

Witnessed by:_____ Date: _____