Intravenous and Oral Chelation Therapy Consent

I _______________________________, am choosing, of my own free will, to receive oral or intravenous Chelation therapy at Auth Vitality: Chelation and Wellness of the Rockies, administered by _______________________________. This alternative therapy, although discounted by conventional medicine, has a long track record of safety.

I understand that Chelation therapy has been historically used for the purpose of treating acute and chronic heavy metal toxicity, atherosclerotic disease, and the prevention or treatment of degenerative and autoimmune diseases. I understand that Chelation Therapy is a standard therapy widely approved for the treatment of heavy metal toxicity, however, its usage is considered controversial for the generalized treatment of the above listed conditions, and the view that it is of benefit in the treatment of such disorders is accepted by a minority of the medical community. I understand that Chelation therapy is considered “experimental” by most medical providers, but I am advised that my treating physician believes that Chelation Therapy does have positive clinical benefit but does not make the promise that positive benefits will be the result. I have been informed that other treatment approaches have been used in these conditions, and these alternatives have been explained to my full satisfaction. As with any other medical procedure, certain patients do not respond to this therapy. 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 treatment are anticipated, and that these treatments may be extended over several weeks to months. I have been informed that Chelation Therapy may need to be repeated from time to time in the future to maintain the benefits.

I have been informed of possible risks and side effects including but not limited to discomfort at the injection site, thrombophlebitis, hypocalcemia, fatigue, muscle cramps, kidney problems including nephrotoxicity, allergic reaction, congestive heart failure, liver disease, anticoagulation, lower 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 physicians, and I have disclosed openly any known previous disorders. I understand that this therapy should not be used if I am pregnant unless I have a severe life-threatening disease. I understand that if I have a history of tuberculosis, 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, I have had the opportunity to ask any questions of my provider with respect to the proposed therapy, and the procedures to be utilized and the risks and dangers have been explained to me to my full satisfaction.

I understand that Auth Vitality: Chelation and Wellness of the Rockies and its clinical providers, make no warranties, claims, or guarantees about these alternative therapies with respect to my condition. I am freely partaking in this treatment, and as such my willing participation in this treatment represents a “good faith” effort by the provider. I have made this decision based on shared decision making with my provider, and I accept the risks vs. benefits as they relate to Chelation therapy. Should harm come to me, I and my representatives will hold harmless Auth Vitality: Chelation and Wellness of the Rockies and its clinical providers.

I agree to have lab work performed as requested by my provider, agree to schedule regular office visits at the requested intervals to continue my Chelation treatments and maintain an up-to-date health history and working relationship with provider during and after treatment. I acknowledge that it is my right to cease Chelation therapy at any time for any reason. I understand that I should follow up with the administering provider within 1-3 days if I should have any symptoms of concern. I am consulting with Auth Vitality: Chelation and Wellness of the Rockies, solely for reasons concerning my own health. I am not consulting to provide information to any enforcement or investigative agency. I understand that this procedure is not covered by insurance carriers and agree to the complete financial responsibility of these services. My Signature on this agreement will constitute a full and final release of any legal responsibility resulting from the administration of Chelation Therapy in my case and/or any other medical treatment that may be necessary as a result thereof. With full awareness of the above facts and considerations, I give my consent to Auth Vitality: Chelation and Wellness of the Rockies and its staff, to receiving one or multiple Chelation infusion treatments.

Patient name: ___________________________Patient signature: _____________________________Date: ___/___/___

Provider name: __________________________Provider signature: ___________________________Date: ___/___/___