INFORMED CONSENT FOR THE NanoSRT WELLNESS SYSTEM

Patient Name__________________________ Telephone Number___________

Address______________________________ City & State_________________

Email:_________________________________

Background: **I desire to be tested to determine possible undesirable reactions to various stressors that are natural constituents of my diet, environment or body chemistry. I understand that the device being used is FDA cleared for Galvanic Skin Response Testing and not intended to directly treat or cure any specific condition, symptom or illness. The physician has explained, and I understand, the benefits of receiving stress reduction and relaxation therapy and the direct relationship between stress, illness and disease.**

Procedures: **I understand that this is a non-invasive procedure (the skin is not pierced). A metal clip or electrodes are attached to the skin to measure electrical conductivity on the hands. Homeopathic remedies, nutritional supplements and other natural remedies may be used to bring abnormal electrical patterns into equilibrium. I understand the nature of the immune system and related symptoms are of an unpredictable nature and therefore the facility cannot guarantee any results.**
______________________________ cannot guarantee that new stressors will not contribute toward my health conditions in the future and that in some cases a person may not wholly respond to the treatment.

I choose to be tested with the NanoSRT Standard-of-Care Wellness System. I understand that this testing has not been scientifically proven to be reliable and that my physician must still rely upon my observations as to the efficacy of the test and any treatment based on the results of this test.

Risks: **The procedure is very safe because it measures only changes in the electrical properties of the skin. However, since an electrical signal is used there is a slight risk or electrical burn or shock. Skin irritation or redness may occur at the site of the test. However, any discomfort should be brief. There are generally no risks associated with the substances recommended to bring your body to equilibrium as long as those substances are taken as recommended, but please report any discomfort you may experience from taking these substances to your examiner or physician. Please report any significant health problems (i.e. Diabetes, High Blood Pressure, etc.) to your physician. I understand that there is a risk factor where as a result of exposure to these bio-energetic stressors, that I may experience temporary symptoms not unusual to the**

regular symptoms currently experienced when exposed to these stressors. I assume all responsibility for the unpredictable immune reactions that may lead to increased symptoms. I agree to seek immediate medical attention should this occur and understand that this facility does not treat cases of patients suffering from anaphylactic allergic reactions and I agree to completely disclose all information regarding any life threatening allergies or allergies resulting in anaphylaxis.

Questions: **I have been provided with the opportunity to ask any pertinent questions I have regarding the NanoSRT procedure, protocol or treatment program.**

Free to Decline: **I understand that I may decline to the NanoSRT testing and therapy.**

Important: **There is no recognized body of scientific evidence to show that an electrically balanced body is more likely to be healthier and you have chosen to participate in this assessment with that understanding. Your physician may need to use other forms of testing in the course of your treatment.**

Payment of Services: **You are responsible for the payment of the normal and necessary fees associated with the NanoSRT Assessment and services performed as a result of that testing, if purchased in this clinic.**

I have read and understand the above information about the NanoSRT Wellness System and my rights and responsibilities and hereby consent to the use of the NanoSRT Wellness System. I consent to the use of clinical reports and results of my case for study, the purpose of advancing clinical knowledge, research and scientific purposes provided that my identity is kept confidential.

Date___________

Name_____________________________Signature___________________________

Signature of Parent or Guardian if Patient is a minor_________________________