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**INFORMED CONSENT FOR Na<sub>2</sub>EDTA or CaEDTA CHELATION THERAPY**

I \_\_\_\_\_ hereby give consent to Dr Jennifer Gentry or her employees or staff to perform intravenous Na<sub>2</sub>EDTA or CaEDTA chelation therapy for the purpose of atherosclerotic disease and/or heavy metal toxicity, and/or prevention of treatment of degenerative disease. 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 atherosclerotic vascular disease and other degenerative disease and the view that it is of benefit in the treatment of such disorders is accepted by a minority of the medical community and is considered "experimental" by most physicians. I am advised that my treating physician believes that Chelation Therapy does have a positive clinical benefit. I have been informed that other treatment approaches have been used in these conditions, including but not limited to bypass surgery, or angioplasty and these alternatives have been explained to me to my full satisfaction. As with any other medical procedure, a small percentage of 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 supplementations). I understand that an initial series of treatment are anticipated and that these treatments may extend over a number of months. I have been informed that Chelation Therapy may need to be repeated from time to time in the future to maintain benefits. I understand that it is my option to stop at any time with this treatment protocol 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, thrombophlebitis, hypocalcemia, fatigue, muscle cramps, allergic reaction, congestive heart failure, lowering of blood sugar levels, fever, chills, kidney problems including nephrotoxicity, liver disease, anticoagulation, mineral loss, and generalized complaints. If I have suffered any previous kidney disease, I agree to execute a medical release so that all previous identified medical records of mine may be obtained from previous physicians, and I have disclosed openly any known previous disorder. I understand that this therapy should not be used if I am pregnant unless I have 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 and the risk and dangers have been explained to me to my full satisfaction.

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 material provided to me by the office to educate me about 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 my questions have been answered to my full satisfaction. My signature on this agreement will constitute full and final release of any legal responsibility resulting from the administration of Chelation therapy in my case or and other medical treatments that may be necessary as a result thereof.

**I agree to have lab work performed and available to Dr Jennifer Gentry when requested. I agree to schedule regular office visits with Dr Jennifer Gentry at the requested intervals to continue my Chelation treatments and maintain an up-to-date health history and working relationship with my physician.**

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name (Signature)