POLO HEALTH + LONGEVITY CENTRE

CHELATION THERAPY

INFORMED CONSENT AND ACKNOWLEDGEMENT

I,____________________________, hereby authorize the physician, ________________________, to administer Chelation Therapy ("CT") for treatment of arteriosclerotic vascular disease and/or heavy metal poisoning(s). I understand and acknowledge that CT is an elective procedure, and that I am not required to undergo CT. I understand and acknowledge that it is critically important to provide my doctor with a full, accurate and complete medical and social history, including, without limitation, any allergies, illnesses and/or diseases which I have or may have, prior to receiving any CT treatments. I understand and acknowledge that my failure to do so may cause my doctor to inaccurately assess my risks and any potential side effects associated with receiving CT.

Explanation of CT Treatment: I understand and acknowledge that CT involves inserting a needle and injecting a prepared formula into my veins or muscles. I understand and acknowledge that a series of 10 treatments is recommended and that those treatments may be spread over a number of months. By signing below, I acknowledge receiving and reviewing the educational article entitled "*EDTA Chelation In The Treatment of Vascular Disease and Other Chronic Conditions"* (attached hereto) which further explains CT, as well as some potential risks and side effects.

Potential Benefits of CT: Although the exact mechanism of action of CT is not clear, it is believed that CT may reduce plaque formations in the blood stream by removing heavy metallic ions from the blood stream and body. Heavy metallic ions promote the uncontrolled growth of free radicals in living tissue, which are believed to contribute significantly to the development of Vascular and/or Coronary Artery Disease. Therefore, by removing the heavy metallic ions from the blood stream, CT may reduce the likelihood and/or adverse effects of Vascular Disease and/or Coronary Artery Disease ("CAD").

People Who Should Not Receive CT:

Occasionally, although rarely, a person treated with CT suffers an allergic reaction to the treatment. I understand and acknowledge it is critically important to inform the doctor of any and all allergies I may have, so that my doctor may accurately assess the risks of CT. I understand and acknowledge that individuals with creatinine clearance of less than 30 ml/min or a serum creatinine level of more than 2.8 mg/dl may require a lower than normal dose of CT. I agree and promise to inform my doctor if I have such a condition, or may have such a condition, prior to receiving any CT treatments. I understand and

acknowledge individuals with severe liver disease may not be suitable to receive CT. I agree and promise to inform my doctor if I have ever been diagnosed with, or if I believe for any reason that I may suffer from any form of liver disease, prior to receiving any CT treatments. I understand and acknowledge that women who are pregnant may not be able to receive CT. I agree and promise to inform my doctor if I am pregnant, or believe that I may be pregnant, prior to receiving any CT treatments.

Potential Side Effects Of CT: I understand and acknowledge and accept that I may experience side effects as a result of CT, which include any or all of the following: (1) general discomfort at the injection site; (2) thrombophlebitis; (3) fatigue; (4) muscle cramps; (5) kidney problems; (6) a temporary drop in blood sugar; (7) aggravation of pre -existing renal impairment (which occurs if the dose of CT is too large or is given too quickly); (8) aggravation of pre-existing congestive heart failure (because of the fluids received as part of the IV infusion of the CT treatment); (9) hypocalcemia with resultant tentany; (10) rarely, seizures may result from receiving too rapid of an infusion of CT treatment; (11) hypotension; (12) hypoglycemia; and the potential removal of several beneficial minerals from the blood stream.

I understand, acknowledge and accept that although my doctor will try to prevent these side effects, they may still occur as a natural result of receiving CT. Hypocalcemia is usually easily corrected with a calcium infusion. Hypoglycemia can be prevented by eating prior to receiving CT treatments. I have been informed that I should bring a protein snack to be eaten during each of my CT treatments. I have also been informed that I should drink water prior to and throughout the treatments.

Lifestyle Changes And Need To Continue CT: I understand and acknowledge that as a result of receiving CT, it may be necessary for me to change my lifestyle to a healthier one, including taking one or more of the following steps: (1) quit smoking; (2) engage in steps to reduce and/or control my weight; (3) regularly engage in exercise; (4) supplement my regular diet with nutritional supplements as outlined by my doctor; and (5) utilize a proper diet, and so forth. I understand and acknowledge that such lifestyle changes may greatly enhance the benefits of CT. I understand and acknowledge that my doctor may recommend that I continue CT in the future from time to time to continue its benefits, and that an initial series of 10 treatments, which may be spread over a number of months) is recommended but may not be sufficient to complete the treatment.

Alternative to CT: I understand and acknowledge that there are alternative treatments which may,

together or separately, provide benefits similar to those provided by CT, including without limitation receiving a coronary bypass. Any available alternative includes its own risks and potential side effects. I understand and acknowledge that I have received information about potential alternatives and their respective risks and side effects. I agree and promise that if I have any remaining questions regarding alternatives, or their respective risks and/or side effects, I will request more information from my doctor or a referral to another doctor who may specialize in one or more of their alternatives, prior to engaging in CT.

Acknowledgment of Informed Consent: I ______________________________________, hereby acknowledge and agree by this statement that I have been fully informed about the risks associated with CT. If I have any additional questions about CT after reading this Consent and Limitation of Liability and the attached article on CT, I will ask my doctor for more information prior to engaging in CT. I understand and acknowledge that additional information about CT is available from a variety of sources and in a variety of forms (for example audio, visual, and written media), and my doctor may be able to provide additional sources of information, or refer me to such additional sources of information, if requested. I agree and promise that I will not proceed with CT until I am comfortable with the information I have received and/or reviewed, and I have had each of my questions answered to my satisfaction.

Personal Responsibility For Payment Of Treatments: I understand that, in most cases, my insurance coverage (including Medicare) will not pay for CT, and that I will therefore be personally responsible for the costs associated with the treatments.

________________________________ ________________________________

Signature of Physician Date Signature of Patient Date

Limitation of Liability for Any and All Claims

This consent and limitation is a contract which affects any rights you may have if you suffer any loss, damage, or injury of any kind as a result of receiving Chelation Therapy ("CT") while under the care of _________________________I _____________________________, understand and acknowledge that CT is an elective treatment, and one which many insurance companies continue to classify as "experimental". Due to the experimental and purely elective nature of CT and the difficulty in assessing patient risk and/or predicting the potential results of CT, my doctor's liability for any and all claims and/or any and all damages related to my CT treatments, including without limitation claims for malpractice, negligence, breach of contract, and/or unfair trade practices will be limited to the amount of the fee paid for the CT services and that my doctor is released from any and all liability, to the fullest extent allowed by law.

I acknowledge, agree and promise that I have been provided with sufficient factual and opinion information to allow me to make an informed decision regarding whether or not to undergo CT. If I elect to undergo CT I acknowledge, agree and promise to waive any and all claims based on allegations that I have not been properly informed of the CT procedure, potential benefits, contraindications, potential side-effects and alternative treatments, regardless of the legal theory under such claims may be brought, to the fullest extent allowed by law. I understand and agree that If I am not comfortable signing this Consent and Limitation of liability, or if I have additional questions about the legal effect of the waiver and/or release provisions herein, I should consult an attorney (at my expense) and/or ask my doctor additional questions. I agree and promise that I will not sign this Consent and Limitation of Liability until I am completely comfortable with the waiver and release provisions herein. I understand acknowledge and agree that my doctor will not provide CT until I agree to each of the provisions set forth herein, and that other doctors, outside of my doctor's office, may provide the same or similar service with a lesser limitation provision. I acknowledge, agree and promise that I have received and reviewed this Consent and Limitation of Liability prior to receiving any CT treatments.

I understand and acknowledge that if a court of competent jurisdiction should decide that any part of the Consent and Limitation of Liability is illegal, unenforceable or void as a matter of public policy or otherwise, such a determination shall not affect the validity, or enforceability of the remaining parts, provisions, subparts, and/or sub-provisions.

________________________________ ________________________________

Signature of Physician Date Signature of Patient Date