



## NAET<sup>®</sup> Treatment Consent Form

I, \_\_\_\_\_, certify that the Doctor/NAET<sup>®</sup> practitioner did not claim to cure any illness or disease with NAET<sup>®</sup> (Nambudripad's Allergy Elimination Techniques).

I understand that NAET<sup>®</sup> is not a medical diagnostic procedure therefore does not diagnose any disease. Rather, NAET<sup>®</sup> gives the practitioner an indication as to the substance(s) to which the patient may have a sensitivity. NAET<sup>®</sup> uses various, standard medically proven diagnostic measures and modalities (Allopathic, Chiropractic, kinesiological and Acupuncture) to diagnose the patient's condition. The premise behind NAET<sup>®</sup> is to desensitize a patient to a substance(s) using Allopathic, Chiropractic, acupuncture/acupressure, nutritional, and kinesiological principles so that the patient may not experience hypersensitive symptoms when they have future contact with them.

I understand that I am (my ward) to continue all medications and other treatment modalities as they have been prescribed unless otherwise directed by the doctor who prescribed them. During the 25 hours or after if I (my ward) get a life-threatening reaction from the allergen I (my ward) was treated or from some other sources, I need to seek emergency help immediately from a physician qualified in emergency treatments, or by calling 911 or attending an emergency room at the local hospital. If I (my ward) am suffering from severe allergic reactions to substances, I should consult an appropriate physician and take appropriated medication (such as medication to prevent itching, tissue swelling, fever, cough, pains, infections, mental irritability, violent behaviors, etc.) to keep my (my ward's) symptoms under control while I (my ward) am treating with NAET<sup>®</sup> treatments. This way, essential NAET<sup>®</sup> treatments can be completed without interruption and once I (my ward) complete the essential NAET<sup>®</sup> treatments for my (my ward's) condition, I (my ward) may not need to continue pharmaceutical drugs indefinitely.

I understand that for 25 hours after the treatment I (my ward) am to avoid eating, touching, breathing and coming within 5 feet of the substance(s) that I (my ward) have received treatment. If I (my ward) come in contact with substance(s) for which I (my ward) am being treated, I realize that the treatment may not work and I (my ward) may have a sensitivity reaction.

I understand that I (my ward) must return after my 25 hours avoidance period preferably within 24 hours but at least within 7 days, to see if I (my ward) have cleared for the substance(s). I fully understand that I (my ward) may still experience a reaction to the substance(s) of unknown severity if I (my ward) come in contact with them if I (my ward) did not clear them completely. If I (my ward) did not clear them completely, I (my ward) may be required to repeat the procedure (more office visits at my cost) until I (my ward) clear them satisfactorily.

I understand that this document will be filed in my records and will apply to my initial session as well as all additional sessions.

I have read or have had read to me the above statements and have had the opportunity to ask questions about its content and by signing below I agree to the terms and procedures.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of the Minor

\_\_\_\_\_  
Relationship to the minor (ward)

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date