

Informed Consent Agreement
NeuroModulation Technique (NMT) Remote Treatment Consent Form
Kinsei, Matthew Buckley DC
2700 Bee Cave Rd Suite 101, Austin, TX. 78746
512-327-1771 phone

NeuroModulation Technique (NMT) is intended to determine the patient's perception of conditions contributing to illness. I desire to be screened with NMT, and hereby consent to participate in this type of screening and treatment. In this case, I am seeking NMT screening and treatment via telephone as I am unable to physically visit the doctors' office.

The procedure has been explained to me, and I understand that certain adverse effects may result from the treatment. These could include, but are not limited to, a temporary flare-up of my symptoms. Other possible side effects include symptoms of heightened immune function or detoxification such as fever, chills, headache, or body aches. I understand that if any unexpected exacerbation of my symptoms should occur, I am solely responsible for obtaining appropriate medical care to address those symptoms or conditions.

I understand that NMT is not a medical diagnostic procedure, and therefore does not diagnose disease. Diagnosis requires particular types of clinical examination procedures by a physician trained in diagnosis. By contrast, NMT is intended to determine the patient's perception of conditions contributing to illness. I understand that Muscle Response Testing, (MRT) employed in NMT, like any medical testing procedure, is not 100% accurate. Since I have chosen to undergo screening and treatment via telephone, I understand that my treatment will be based upon surrogate muscle testing as of response to semantic queries and statements the practitioner verbally delivers to me. I understand that the efficacy of such treatment has been both established and refuted in published scientific literature.

I understand that alternative methods of treatment are available. These have been described to me. If I am suffering from severe allergenic reactions to substances, or any health condition for which I have been prescribed medications to control dangerous symptoms, I will consult an appropriate physician and, if so advised, take medication (to prevent itching, tissue swelling, fever, cough, pains, etc.) to keep my symptoms under control while I am being treated with NMT.

I understand that determination of the existence and identification of particular infectious agents in the body requires specific laboratory testing. NMT does not diagnose any infectious agent, nor is it a substitute for appropriate lab testing. Rather, NMT evaluates the perceptions of the autonomic control system, and immune system with regard to such issues, and attempts to optimize autonomic function with respect to immune system control.

NMT is not a method of diagnosing or treating cancer. Medical oncologists are the only health care personnel appropriately trained to manage the treatment of cancer. NMT is not a substitute for appropriate medical care of cancer. I understand that I am not being asked to discontinue any concurrent medical care. Moreover, I understand that it is recommended that I do not discontinue any care prescribed by my doctors.

I understand that nutritional, herbal, or homeopathic products recommended for use by Dr. Buckley's office are not meant to diagnose, treat, or cure any disease. These supplements can result in possible side effects. Possible side effects include but are not limited to the symptoms of heightened immune function or detoxification such as fever, chills, headache, or body aches.

contact with and treatment from medical practitioners, and communicating progress and side effects to the health care provider administering NMT. I understand that I am to continue all medication and other treatment modalities as they have been prescribed unless otherwise directed by the doctor who prescribed them.

I understand that there is no guarantee concerning the effect of the treatment. I understand that I am free to discontinue treatment at any time, but acknowledge that I am responsible for full payment of the normal and

Please initial after reading this page _____

necessary fees associated with my screening and treatment. I understand that if I terminate treatment without the recommendation of my NMT practitioner, that this may adversely influence the degree or durability of improvement from my treatment. I agree that if I am being treated for allergies causing dangerous symptoms such as anaphylactic response, or for any condition that is aggravated by certain activities or exposures, that I will not expose myself to such risk of aggravation except as advised by NMT practitioner under controlled and defined circumstances. I understand that if I expose myself to such aggravating factors prematurely, this may pose a risk to my health.

I understand that any services that are being provided on a remote basis are my sole financial responsibility, and that no aspect of such services may be billed to insurance companies for the purposes of reimbursement. I understand and authorize all charges in advance of treatment, and I am fully financially responsible of any cancellation of sessions without **48** hours notice.

I further agree to be interviewed during this teleconference, and that this interview and my voice may be audio taped. I understand that these recorded audiotapes may be used for telephone consultation evaluation, research and NMT encounter purposes only, at both the transmitting and receiving facilities, and that my identity will not be disclosed except where medically necessary. I understand that without prior written consent, said recorded tapes will not be broadcast or otherwise played outside the health care or educational setting.

I also understand that clinical data is presently being collected on the techniques that require the gathering of certain information for publication in a scientific journal, and that a number or letter designating my case, but not my name, may be used in reports of this study.

I have read, or have had read to me, the above statements, and have been provided with the opportunity to ask any pertinent questions I have regarding this screening and treatment program. I have been informed that I am to contact the doctor if any problems are encountered during my treatment. I understand the conditions stated above, and hereby consent to participate in this type of screening and treatment. By signing below I agree to the terms and procedures set forth above.

I have executed the foregoing this ____ day of _____, _____.

Patient's Signature

Patient's Printed Name

If Minor, signature of parent or guardian

Parent or Guardian's Printed Name

Practitioner