Informed Consent:
WTS Treatment

Indigo Integrative Health Clinic

Disclosure and Consent

Patient: You have the right, as a patient to be informed about your condition and recommended treatment, and/or diagnostic procedures to be used so that you may make an informed decision whether or not to undergo the procedures after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you. It is simply an effort to make you better informed of the risks and possible complications, so you may give or withhold your consent to the procedure.

I (We) voluntarily request Indigo Integrative Health Clinic practitioners, as my physician and such associates, technical assistants and other health-care providers as he deems necessary, to treat my condition which has been explained to me as Wilson's Temperature Syndrome, (Hypo metabolism not explained by blood tests). I (We) understand that the following treatments, as well as certain diagnostic procedures are planned for me, which include but are not limited to (T3 time released compounded thyroid, synthroid, cytomel, as well as natural supplements that may be used). I (We) understand that my physician may discover other or different conditions, which require additional and different procedures than those planned. I (we) authorize my physician, and such technical associates, technical assistants and other health-care providers to perform procedures which are advisable in their professional judgment. I (We) understand that no warranty or guarantee has been made to me as to a result or cure. Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of these treatment and /or said diagnostic procedures: the potential for heart attacks, cardiac arrhythmias, strokes, allergic reactions, or other side effects including death may occur. I (We) also realize that the following side effects or symptoms may occur in connection with this particular procedure: increased heart rate increased or decreased blood pressure, tremors palpitations, headaches, nausea, lightheadedness/fainting, and sweating. I (We) understand that the medical and/or diagnostic procedures planned for me represent a relatively recent medical advancement and are not endorsed by either the AMA or the American Thyroid Association, and may not be well understood or approved of by other physicians or health professionals involved in my (our) health care. However there are a large number of physicians around the world using this procedure and they have indicated by affidavit their acceptance and use of these procedures, so that they are not considered experimental and are used by a number of alternative medical practitioners. I (We) understand that the protocols used are very precise and quite rigorous and I (we) understand the importance of complying with the treatment program exactly as prescribed, and the importance of not stopping the medications abruptly. I (We) have been given an opportunity to as questions about my (our) condition, alternative forms of treatment, risks of non-treatment, the procedures to be used and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give consent. I (We) certify this has been fully explained and that I (we) have read it or have had it read to me (us), and that I (we) fully understand its contents.

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The undersigned consents to any laboratory, physical or other examination, deemed necessary to safely undertake treatment as well as consent to treatment rendered the patient by physicians and the designated clinic personnel, nurses, licensed practical nurses, dietitians and other persons who are not licensed physicians, but who are deemed by the physician to be trained to assist under the general and specific instruction provided by them, I (we) further agree that the results of these procedures may be known to scientific publications and/or such government agencies as may be necessary. I (We) further understand that some of the supplements used and treatment may not be covered by insurance and agree to be responsible for the charges that may result from supplements, medication or treatment that my (our) insurance company may not cover. I (We) further understand that I may revoke this authorization at any time by written request.

Patient's Signature _______________ Date _______________

Address _______________

Witness _______________