

Informed Consent

I authorize the use of alternative evaluation and treatment with the possible use of microcurrent stimulation (MCS), phototherapy and nutritional supplementation. I may or may not be a candidate for these therapies and I am seeking the advice of Dr. Michael J. Siebert.

While undergoing these approaches I will remain under the care of my medical doctor and I will have my health and vision checked on a routine basis. My existing doctor may offer other therapies which may not be available at the time of this consent and I will consider those options as well.

While utilizing the microcurrent stimulation, phototherapy or nutritional supplementation to compliment my regular medical treatment program I will not discontinue the use of any medication or treatment recommendations without consulting my medical doctor.

I understand that MCS is an “off-label” use of an FDA-approved medical device.

I understand that insurance does not cover the cost of MCS, phototherapy and nutritional supplementation. I also acknowledge that no assurances, claims or guarantees have been given to me as to the results that may be observed.

I have been given accurate information as to the condition of my health. I do not have any contraindications to the therapies that I plan to undergo. By signing below, I acknowledge that I have read and understand the above information.

Signature: _____ Date: _____

Witness: _____ Date: _____