PATIENT'S INFORMED CONSENT DOCUMENT

PATIENT IS TO READ EACH PARAGRAPH
AND SIGN AT THE BOTTOM OF EACH PAGE

Patient's Name: _____
Address: _____
Telephone: _____ - _____ **Date of Birth:** _____
Age: _____ **Sex:** Male Female

Name and Address of Physician

Dr. Robert Battle
Comprehensive Health Association
9910 Long Point Road
Houston, TX 77055

I have specifically sought out the services and perspective of Dr. Robert Battle for the way in which he practices Complementary and Alternative Medicine. Dr. Battle has explained to me and I fully understand the following:

(a) Much of Dr. Battle's treatment being recommended is not recognized as traditional, but is an alternative method. Complementary and Alternative Medicine, like any other treatment or medication, may or may not alleviate or cure the condition(s) for which it is offered.

(b) Your physician believes that Complementary and Alternative Medicine may be valuable to your health. However, as with any type of treatment or testing, you should fully understand the potential risks and benefits of the testing, as well as other available testing options, including lab work, before deciding whether the work-up and following medical analysis and possible treatment provided by Dr. Battle is right for you. It is important that you read and understand the information contained in this form so that you can make an informed choice about being treated at Comprehensive Health Association, by its agents, and Dr. Robert Battle, specifically. If after reading this form, you have any concerns or questions regarding this testing you should talk to your provider.

(c) The federal government, including Medicare and Medicaid, and most insurance companies, do not generally pay or reimburse for intravenous treatments and vitamin and mineral supplementations by Dr. Battle.

(d) Some of the testing being recommended at Comprehensive Health Association are not recognized as traditional, but are alternative testing methods.

I have read and understand the content of this page _____.

(e) The United States Food and Drug Association ("FDA") reviews the safety and effectiveness of particular uses of drugs but does not forbid physicians to use approved medications for off-label use.

(f) Some of the treatments being offered at Comprehensive Health Association are not FDA approved.

(g) Some of the treatments prescribed at Comprehensive Health Association are not FDA approved.

(h) Some of the formulations prescribed at Comprehensive Health Association have never been tested by the FDA for determination of the actual contents or the medical effectiveness of the formulations.

(i) The medical/scientific proof of effectiveness/therapeutic value of some of the treatments is disputed.

(j) While your treating doctor believes that the alternative and comprehensive treatments may be beneficial to your health and well-being, the traditional medical and scientific communities often dispute the medical/scientific proof of the effectiveness or therapeutic value of the treatments. You are free to contact any medical group, doctor, or association on their view of any testing or treatment before you begin. Dr. Battle believes the testing and treatment he oversees are valuable and might improve your health.

(k) I may leave Comprehensive Health Association at any time. It was my independent choice whether to see Dr. Battle and it is always my choice whether to continue with him. I also understand that Dr. Battle reserves the right, at any time and without cause, to discontinue any patient due to poor compliance with Dr. Battle's recommended program for any other reason.

THE TESTING AND TREATMENT BEING UTILIZED AND DESCRIBED BY RESPONDENT IN THIS DISCLOSURE STATEMENT IS NOT ENDORSED, APPROVED, ACCEPTED, OR SUPPORTED BY THE TEXAS MEDICAL BOARD.

I have read and understand the content of this page _____.

I, THE UNDERSIGNED, HAVE READ AND FULLY UNDERSTAND THE ABOVE INFORMATION, THE ELEMENTS OF MY INFORMED CONSENT, MY RIGHTS AND RESPONSIBILITIES, AND HEREBY GIVE CONSENT TO UNDERGO ALTERNATIVE AND COMPREHENSIVE TREATMENT AT COMPREHENSIVE HEALTH ASSOCIATION. INFORMATION ABOUT ME AND MY RECORDS WILL BE CONFIDENTIAL. DATA WILL BE STORED SECURELY AND WILL BE MADE AVAILABLE ONLY TO THE PERSONS PARTICIPATING IN MY EVALUATION AND SUBSEQUENT TREATMENT, IF ANY, UNLESS I SPECIFICALLY GIVE PERMISSION IN WRITING UNLESS OTHERWISE REQUIRED BY LAW.

Patient Date

Witnessed Date

I have read and understand the content of this page _____.