Sunshine
Health Care Center

13660 N 94th Drive, Ste. C-4
Peoria, AZ 85381-4841

ph (623) 266-1722
fax (623) 266-1746

INFORMED CONSENT FOR Na2 EDTA or Ca EDTA CHELATION THERAPY

I _____, hereby give consent to *Sunshine Health Care Center, PLLC* and specifically *Dr. Tiffany Mitchell*, her associates, employees or staff, to perform intravenous Na2 EDTA chelation therapy ("Chelation Therapy") for the purpose of treatment of atherosclerotic disease and /or heavy metal toxicity, and /or prevention of treatment of degenerative diseases. I understand that Chelation Therapy is a standard therapy widely approved for the treatment of heavy metal toxicity, however, its usage is considered controversial for the generalized treatment of atherosclerotic vascular disease and other degenerative diseases, and the view that it is of benefit in the treatment of such disorders is accepted by a minority of the medical community and it is considered "experimental" by most physician, I am advised that my treating physician believes that Chelation Therapy does have positive clinical benefit. I have been informed that other treatment approaches have been used in these conditions, including but not limited to bypass surgery or angioplasty and these alternatives have been explained to my full satisfaction. As with any other medical procedure, a small percentage of patients do not respond to this therapy.

I understand that the benefits of Chelation Therapy are much greater if I follow a healthy lifestyle (non-smoking, weight control, proper exercise, proper diet, and nutritional supplementation). I understand that an initial series of treatment are anticipated, and that these treatments may be extended over a number of months. I have been informed that Chelation Therapy may need to be repeated from time to time in the future in order to maintain the benefits. I understand that it is my option to stop at any time this treatment protocol without incurring any further expenses after I have directed that such treatment be stopped.

I have been informed of possible risks and side effects including but not limited to discomfort at the injection site, thrombophelebitis, hypocalcemia, fatigue, muscle cramps, kidney problems including nephrotoicity, allergic reaction, congestive heart failure, liver disease, anticoagulation, lower blood sugar levels and / or hypoglycemia, mineral loss and generalized complaints. If I have suffered from any previous kidney disease, I agree to execute a medical release so that all previous identified medical records of mine may be obtained from previous physicians, and I have disclosed openly any known previous disorders. I understand that this therapy should not be used if I am pregnant unless I have a severe life threatening disease. I understand that if I have a history of tuberculosis, Chelation Therapy may reactivate arrested tuberculosis and I agree to inform my physician of any occurrence of this disease. I understand the nature of the proposed procedure and the risks and dangers have been explained to me to my full satisfaction.

While I understand that there have been no warranties, assurances or guarantees of successful treatment made to me, I desire to undergo this treatment after having considered the information contained in this document, the information provided to me through my conversations with my treating physician and though materials provided to me by the office to educate me about the treatment. I acknowledge that I have had the opportunity to ask any questions of my physician with respect to the proposed therapy and the procedures to be utilized and all my questions have been answered to my full satisfaction. My Signature on this agreement will constitute a full and final release of any legal responsibility resulting from the administration of Chelation Therapy in my case and/or any other medical treatment that may be necessary as a result thereof.

I agree to have lab work performed and available to Dr. Mitchell when requested. I agree to schedule regular office visits with Dr. Mitchell at the requested intervals in order to continue my Chelation treatments and maintain an up-to-date health history and working relationship with physician.

Patient Signature _____ Date _____

Patient Name (print) _____

Doctor Signature _____

Dr. Tiffany Mitchell, N.M.D