S1 TEST ORDER NDA

BAIN MED

DR. ALAN BAIN, DO

PATIENT FIRST NAME	PATIENT LAST NAME	PATIENT D.O.B.

SHIPPING ADDRESS	CITY	STATE	ZIP CODE

PATIENT EMAIL	PATIENT PHONE #1	PATIENT PHONE #2

OCCUPATION	EMPLOYER	EDUCATION LEVEL

_____ I, the undersigned patient or representative or legal guardian of the minor named above, give the following consent.

_____ I am attempting to learn more about the Covid-19 spike burden in my body from having had the mRNA vaccine or having contracted Covid-19.

_____ My "referring provider" has informed me that I may benefit from the test described by this Consent (the "Test"), because the test "Basic S1 Immune Subset Panel" may help my referring physician select the most viable avenue for detoxifying my body.

444 N Northwest Hwy
Suite 200
Park Ridge, IL 60068

P: 312 - 236 - 7010
F: 312 - 236 - 7190

patientservices@docintheloop.com

S1 TEST ORDER NDA

BAIN MED

DR. ALAN BAIN, DO

IMPORTANT NOTICE:

The U.S. Food and Drug Administration (FDA) has NOT approved or cleared this test. However, FDA approval or clearance is not required to use the test for this consent.

This basic S1 Spike Protein with Immune Subset blood test (S1) has been made available for clinical research by Dr. Alan Bain, D.O. The pricing and specifics of this (S1 Spike Protein) test have been negotiated solely for the ongoing study of the Homeopathic Spike Detox (HSD) protocol. Any use of this (Spike Protein S1) test outside of (HSD) or personal research, without going through Dr. Bain, D.O., violates his agreement and may incur a $25,000 fine per violation. This S1 Spike Protein with Immune Subset panel does not cover all tests offered by IncellDx. Currently, only tests for classical, intermediate, and nonclassical monocytes with S1 Spike Protein are available; tests for CD4, CD8, the CD4:CD8 ratio, or CBC are not included.

The test determines if I am still encumbered with spike protein which may still challenge my immune system. The test measures S1 spike proteins in monocyte and analyzes if spike protein is still attached. The test was developed by IncellDx, Ca, and its performance characteristics were determined by Radiance Diagnostics. Radiance will conduct the test at Radiance's laboratory, which is separate from Dr. Alan Bain, D.O.'s office. Within 5-7 business days after Radiance received the blood specimen, Radiance will prepare a report indicating the results of the test, which Radiance will deliver to the ordering Physician, Dr. Alan Bain, D.O. and forwarded to your referring physician.
The U.S. Food and Drug Administration (FDA) has not approved or cleared this test. However, FDA approval or clearance is not required to use the test for this consent.
Radiance is a CLIA-Certified high-complexity laboratory. Dr. Alan Bain, D.O. will remit payment for the test to Radiance.

PLEASE INITIAL NEXT TO EACH STATEMENT

_____ The cost of the test may not be covered by my insurance. I understand and I am financially responsible for the full cost of the test, and I voluntarily consent to pay Dr. Alan Bain, D.O. for the test in full, in advance and in the amount of **$360.00 USD (the test cost)**. This test is given at a specialized discount to protect any conflicts of interest. The test fee does not include any telehealth or office visits with Dr. Alan Bain, D.O.

_____If I am not working with a provider, I agree to an informed consent consultation with Dr. Alan Bain, D.O. concerning the Test in addition to the above information. I understand the test results review and consultation fee with Dr. Alan Bain is not included in the test kit fee. If you do not have insurance coverage, choose to waive my right to bill insurance OR if I am located outside of Dr. Bain's practicing

444 N Northwest Hwy
Suite 200
Park Ridge, IL 60068

P: 312 - 236 - 7010
F: 312 - 236 - 7190

patientservices@docintheloop.com

S1 TEST ORDER NDA

BAIN MED

DR. ALAN BAIN, DO

area, an Alternative Homeopathic visit fee of $227 will be due at the time of my visit.

_____I will refrain from discussing the results of my lab, the test price or information obtained during this process publicly, privately and on any social media and chat group.

_____I understand that COVID Long Hauler Cytokine panel, S1 and Immune Subset panel tests are Laboratory Developed Tests (LDT). This test panel was developed by incellDx and their performance characteristics were determined by Radiance Diagnostics, which is certified under the Clinical Laboratories Improvement Amendments of 1988 (CLIA) as qualified to perform high complexity testing. The U. S. Food and Drug Administration (FDA) has not reviewed, approved, or cleared these tests.

_____I understand that the laboratory tests performed at Radiance Diagnostics are done at my request. In consideration for receiving the opportunity to participate in laboratory testing , which is provided by The Radiance Diagnostics, I hear by release, waive, discharge, covenant not to sue, and agree to hold harmless for any and all purposes company and their healthcare staff, members, shareholders, officers, servants, agents, volunteers, or employees (herein referred to as “indemnities”) from any and all liabilities, claims, demands, injuries, (including death), or damages, including court costs and attorney’s fees and expenses, that may be sustained by me while participating in testing.

_____I understand I am responsible for any fees associated with having my blood sample drawn. Phlebotomist fees are not included in the home test kit fee. I am fully responsible for scheduling and locating a phlebotomist to draw my sample. I AGREE to send my sample back to the lab no later than WEDNESDAY to ensure proper delivery and processing time.

_____I am fully aware that, the company is not providing medical care or medical diagnosis with Testing. I further understand that it is my responsibility to consult my own medical doctor for interpretation, analysis, evaluation, and explanation of my test results. I understand that neither Radiance Diagnostics nor its ordering physician will analyze, evaluate, critique, or otherwise interpret the results of said tests. I agree that Radiance Diagnostics, its officers, shareholders, directors, employed physicians or its other agent or employee shall not be liable for any claims including, but not limited to, any claim arising out of or related to, inaccurate, uninterrupted, misinterpreted or results not received and do hereby expressly forever release and discharge all claims, demands, injuries, damage, actions or causes of action.

_____I hereby waive my rights regarding protected health information under HIPAA, to the extent necessary to complete the Testing and to allow Company to provide the results of Testing to the organization which has arranged for the testing or me. Protected health information will not be reused or disclosed by Company to any person or entity other than above, except as required by law.

444 N Northwest Hwy
Suite 200
Park Ridge, IL 60068

P: 312 - 236 - 7010
F: 312 - 236 - 7190

patientservices@docintheloop.com

S1 TEST ORDER NDA

BAIN MED

DR. ALAN BAIN, DO

_____I understand that there is no refund once the kit has been ordered through Dr. Alan Bain, D.O.

PLEASE NOTE:

You are responsible for finding a phlebotomist to draw your blood and any fees associated with that service. We suggest https://www.anylabtestnow.com

TEST ORDERING: [BS1IMST] SARS-COV2-S1-IMMUNE SUBSET PANEL

Are you currently COVID 19 PCR Positive? _____ YES _____NO
If YES, what is the date you first tested positive? _____

Current Symptoms (Circle all that apply)

Fatigue	Loss of smell
Shortness of breath	Sensitivity
Temperature	Brain Fog
Loss of Taste	Cough
Neuropathy	Insomnia
Chills	Joint Pain
Chest Pain	Rash
Gastrointestinal Issues	Myalgias
Tachycardia	N/A

444 N Northwest Hwy
Suite 200
Park Ridge, IL 60068

P: 312 - 236 - 7010
F: 312 - 236 - 7190

patientservices@docintheloop.com

S1 TEST ORDER NDA

BAIN MED

DR. ALAN BAIN, DO

NAME OF REFERRING PROVIDER, PHONE AND EMAIL:

_____

_____

Terms, Cancellation Policy:

I understand that COVID Long Hauler Cytokine panel, S1 and Immune Subset panel tests are Laboratory Developed Tests (LDT). The U. S. Food and Drug Administration (FDA) has not reviewed, approved, or cleared these tests.

I understand that the laboratory tests performed are done at my request. In consideration for receiving the opportunity to participate in laboratory testing , I hear by release, waive, discharge, covenant not to sue, and agree to hold harmless for any and all purposes company and their healthcare staff, members, shareholders, officers, servants, agents, volunteers, or employees (herein referred to as “indemnities”) from any and all liabilities, claims, demands, injuries, (including death), or damages, including court costs and attorney’s fees and expenses, that may be sustained by me while participating in testing.

I am fully aware that, the lab company is not providing medical care or medical diagnosis with Testing. I further understand that it is my responsibility to consult my own medical doctor for interpretation, analysis, evaluation, and explanation of my test results. I understand that neither the lab nor its ordering physician will analyze, evaluate, critique, or otherwise interpret the results of said tests. I agree that the lab, its officers, shareholders, directors, employed physicians or its other agent or employee shall not be liable for any claims including, but not limited to, any claim arising out of or related to, inaccurate, uninterrupted, misinterpreted or results not received and do hereby expressly forever release and discharge all claims, demands, injuries, damage, actions or causes of action.

I hereby waive my rights regarding protected health information under HIPAA, to the extent necessary to complete the Testing and to allow Company to provide the results of Testing to the organization which has arranged for the testing or me. Protected health information will not be reused or disclosed by Company to any person or entity other than above, except as required by law.

Cancellation and Refund Policy: I understand, I may cancel the order before my consultation with Dr. Alan Bain. Refunds cannot be given once the test kit has been ordered and shipped.

444 N Northwest Hwy
Suite 200
Park Ridge, IL 60068

P: 312 - 236 - 7010
F: 312 - 236 - 7190

patientservices@docintheloop.com

S1 TEST ORDER NDA

BAIN MED

DR. ALAN BAIN, DO

S1 PRIVATE STUDY QUESTIONNAIRE:

The Covid-19 vaccination program was rolled out early in December 2020 with 50% of the total vaccinations being conducted by the end of June 2021. Do you remember the approximate date of your FIRST vaccination(s)?

PLEASE LIST ANY COVID-19 VACCINATION YOU HAVE RECEIVED WITH APPROX. DATE OF FIRST DOSE.

_____

_____

WHICH COMPANY DEVELOPED THE COVID-19 VACCINATION YOU RECEIVED? _____

PLEASE INDICATION HOW MUCH YOU AGREE OR DISAGREE WITH THE FOLLOWIN STATEMENT. THE COVID-19 VACCINE NEGATIVELY EFFECTED MY HEALTH.
(STRONGLY AGREE, AGREE SOMEWHAT, NEITHER AGREE OR DISAGREE, DISAGREE SOMEWHAT, STRONGLY DISAGREE)

_____

_____

PLEASE LIST ANY SYMPTOMS YOU BELIEVE MAY HAVE BEEN CAUSED BY THE VACCINE, WHEN THEY STARTED AND IF THEY STILL PERSIST.

_____

_____

PLEASE LIST ANY DISEASE DIAGNOSIS OR CHRIONIC CONDITIONS THAT HAVE OCCURRED PIOR TO YOUR VACCINATION.

_____

HAVE ANY OF THE ABOVE GOTTEN WORSE AFTER TAKING THE COVID-19 VACCINATION? IF YES, WHAT CONDITION WORSENED AND HOW?

_____

PLEASE LIST ANY DISEASE DIAGNOSIS OR CHRONIC CONDITION THAT OCCURRED AFTER YOUR COVID-19 VACCINATIONS.

_____

444 N Northwest Hwy
Suite 200
Park Ridge, IL 60068

P: 312 - 236 - 7010
F: 312 - 236 - 7190

patientservices@docintheloop.com

BAIN MED

DR. ALAN BAIN, DO

S1 TEST ORDER NDA

HOW MANY TIMES HAVE YOU BEEN INFECTED WITH OR BELIEVE YOU'VE BEEN INFECTED WITH COVID-19, BY YEAR. PLEASE NOTE HOW MANY TIMES NEXT TO EACH YEAR.

2019 _____
2020 _____
2021 _____
2022 _____
2023 +_____

HOW MANY COVID CLINICS HAVE YOU SEEN?

_____

HOW MANY SPECIALIST OR TRADITIONAL DOCTORS HAVE YOU SEEN?

_____

SINCE COVID-19, HAVE YOU RECEIVED NEW DIAGNOSIS?

_____

PLEASE LIST ANY SUPPLEMENTS AND MEDICATIONS YOU ARE CURRENTLY TAKING.

_____

PLEASE LIST ANY TREATMENTS YOU HAVE TRIED BUT HAVE FAILED.

_____

WE WILL BE IN CONTACT WITH YOU FOR PAYMENT WITHIN 48 HOURS

_____

SIGNATURE PRINTED NAME DATE

444 N Northwest Hwy
Suite 200
Park Ridge, IL 60068

P: 312 - 236 - 7010
F: 312 - 236 - 7190

patientservices@docintheloop.com