Informed Consent Agreement

I, _____, would like Dr. Ben Erlandson to evaluate and treat me (or my dependent) with LymeStop (LS) and CranioBiotic Technique (CBT), hereafter referred to as LS/CBT.

I understand that LS/CBT is not a medical diagnostic procedure, and therefore does not diagnose or treat a disease. I understand that the identification of allergens, infectious agents, toxins, or biochemical dysfunction requires specific medical laboratory procedures, which the LS/CBT evaluation is not a substitute for. Instead, the purpose of the LS/CBT evaluation is to determine how the patient's nervous system perceives those types of issues. LS/CBT treatment then attempts to optimize the immune system's recognition of those problems so that it can effectively correct them.

LS/CBT utilizes Muscle Response Testing, which like any medical testing procedure, is not 100% accurate. I understand that certain medical testing procedures (especially allergy testing) may not reveal the same results as my LS/CBT evaluation. I also understand that other types of care are available for my health problem(s).

I understand that LS/CBT, like other treatment methods, is not effective for every person's symptoms, and results are not guaranteed. I also understand that my symptoms will improve only if the cause(s) of those symptoms are successfully identified and corrected with LS/CBT procedures.

I understand that LS/CBT is not an effective treatment for life-threatening (anaphylactic) allergies, and that I must never expose myself to life-threatening allergens. I also understand that LS/CBT is not a method of diagnosing or treating cancer, and that medical oncologists are the only doctors who are qualified to perform those procedures.

The LS/CBT treatment has been explained to me, and I understand that certain immune responses or detoxification symptoms may result from my treatment. These may include, but are not limited to: fatigue, fever, chills, nausea, headache or body aches. I understand that if any unexpected flare-up of my symptoms should occur, I am responsible for obtaining appropriate medical care for those symptoms.

I understand that I am not being asked to discontinue any other type of care that has been prescribed by my doctor(s), unless otherwise directed by the doctor(s) who prescribed them. I also understand that any improvement in my health that results from my LS/CBT treatment may result in a change in the dosage for my medication which other doctors have prescribed for me. I agree that I will consult my medical provider to determine if my prescription needs to be changed.

Please initial after reading this page_____ continue on other side

I agree to cooperate with my LS/CBT treatment by maintaining a positive attitude concerning my care, continuing treatment with my other health care providers, and telling those providers about any symptoms which may or may not be related to my LS/CBT treatment. I understand that I may discontinue my LS/CBT treatment at any time. However, I understand that the premature termination of my care may be detrimental to any improvement I have obtained.

I have read the above statements, and I have been provided the opportunity to ask any questions regarding LS/CBT procedures. I have also been informed that I am to notify Dr. Erlandson if I develop any problems during my treatment. I understand the conditions stated above, and hereby consent to participate in this type of care. By signing below, I agree to the terms set forth above.

Date_____

_____ _____

Patient's Signature Patient's Printed Name

_____ _____

If Minor, signature of parent or guardian Parent or Guardian's Printed Name