

## INFORMED CONSENT AGREEMENT

Patient Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

Address \_\_\_\_\_ City & State \_\_\_\_\_

I desire to be tested to determine possible undesirable reactions to various substances that are natural constituents of my diet, environment or body chemistry. I understand that the testing procedure to be used is not generally employed by the majority of physicians for this purpose.

I choose to be tested electrodermally. I understand that electrodermal testing has not been scientifically proven to be reliable and that my physician must still rely upon my observations as to the efficacy of the test and any treatment based on the results of this test.

I understand that other methods of allergy testing and treatment are available. These have been described to me.

I understand that I may decline to participate in the electrodermal testing and can choose instead to have other allergy testing, including a scratch test or blood tests for antibodies.

I understand that I am responsible for payment of the normal and necessary fees associated with my tests and treatment.

I have been provided with the opportunity to ask any pertinent questions I have regarding this testing and treatment program.

I understand that the Nebraska Medical Association does not currently find demonstrated scientific basis for this testing technique.

IN WITNESS THEREOF, I have executed the foregoing this \_\_\_\_ day of \_\_\_\_ 20\_\_

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Witness

If under 18 yrs. old, Parent or Guardian must also sign \_\_\_\_\_  
Parent Signature

# INFORMED CONSENT FOR MERIDIAN STRESS ASSESSMENT

**Background:** There is evidence to support a relationship between both conscious and subconscious stress and the electrical resistance of the skin. Therefore, procedures that monitor electrical resistance of the skin and changes in skin resistance provide useful indications of stress. **Meridian Stress Assessment (MSA)** systems are designed to help identify particular patterns associated with various types of stress reactions and agents which reduce those reactions.

**Procedures:** The procedure is totally non-invasive (the skin is not pierced). A metal probe is touched to the skin to measure electrical conductivity at responsive points, typically on the hands and feet. Homeopathic remedies, nutritional supplements and other natural remedies are used to bring abnormal electrical patterns into equilibrium.

**Risks:** The procedure is very safe because it measures only changes in the electrical properties of the skin. However, since an electrical signal is used there is a slight risk of electrical burn or shock. The only discomfort commonly felt is where the stylus touches a location on the skin. Skin irritation or redness may occur at the site of the test. However, any discomfort should be brief. There are generally no risks associated with the substances recommended to bring your body to equilibrium as long as those substances are taken as recommended, but please report any discomfort you may experience from taking these substances to your examiner or physician. Please report any significant health problems (i.e. Diabetes, High Blood Pressure, etc) to your physician.

**Questions:** Your examiner will answer any questions about Meridian Stress Assessment that you may have. Please do not hesitate to ask any questions regarding MSA

**Free to Decline:** You are free to decline MSA services, or to withdraw consent and to discontinue participation at any time without prejudice to you.

**Important:** There is no recognized body of scientific evidence to show that an electrically balanced body is more likely to be healthier and you have chosen to participate in this assessment with that understanding. Your physician may need to use other forms of testing in the course of your treatment.

**Payment for Services:** You are responsible for the payment of the normal and necessary fees associated with the MSA and any remedies, supplements, or herbals recommended as a result of that testing, if purchased in this clinic. Your physician may need to use other forms of testing in the course of your treatment.

**I have read and understand the above information about Meridian Stress Assessment and my rights and responsibilities and hereby consent to the use of the MSA System. I consent to the use of clinical reports and results of my case for study, the purpose of advancing clinical knowledge, research and scientific purposes provided that my identity is kept confidential.**

Name \_\_\_\_\_ Date \_\_\_\_\_  
(please print)

Signature \_\_\_\_\_

Signature or parent or guardian if patient is a minor \_\_\_\_\_