McDonagh Medical Center

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Nutrition · Allergies · Family Practice · Degenerative Diseases · Preventative Medicine · Metabolic Disorders · Prolotherapy

I, _____, hereby acknowledge by this statement that I have been fully informed that some and perhaps all of the medical services provided at McDonagh Medical Center on or after this date may be "Non-Covered" services and not considered reasonable and necessary under the Medicare program and/or other medical insurance. I realize that my insurance coverage and/or Medicare will deny payment for such services are not medically necessary and/or a non-covered service. I also understand there will be an additional charge for the follow-up appointment with the physician to get results. I will be personally responsible for payment to McDonagh Medical Center for all such services and procedures.
Services include any or all of the following:

X-rays	Hair Analysis
Plethysmography	Cytotoxic Food Testing
Blood test (Labs)	Hyperbaric Oxygen Therapy
Candida Skin/Blood Test	Nebulizers
Reconstructive Injections (Prolotherapy)	EKG
Treadmill (Stress Test)	Spirometry
Allergy Testing	Chelation Therapy
Prolozone Therapy	Ozone 10 Pass
Direct IV	Infrared Sauna
IonCleanse Foot Bath	O3 Insufflation

I have read, understand and agree to the above.

_____ _____
Signature Date

CHELATION THERAPY

I additionally understand that I am embarking on a series of EDTA Chelation Therapy treatments which will be administered on an intermittent basis from the date of signature to the completion of the Chelation Therapy program. During this time, I may also receive certain injectable medicines in conjunction with my treatments, which may include but are not limited to GH-3, Vitamin B12, Lasix, Adenosine and Colchicine.
I also understand that I am fully responsible for any and all expenses incurred by me to McDonagh Medical Center. I hereby understand and agree to the above.

_____ _____
Signature Date