N.A.E.T. TREATMENT CONSENT AND RELEASE OF LIABILITY FORM

Please complete both sides of this form

Mark W. Light, M.D., N.A.E.T. Certified Practitioner
Vickie Van Scyoc, R.N., N.A.E.T. Certified Practitioner
530-899-7300

Name of patient (PLEASE PRINT)_____

Name of parent or guardian if patient is a minor _____

FINANCIAL RESPONSIBILITY

Initial visit costs $175 and includes: One hour with Mark W. Light, M.D.,
2 mandatory books, balancing, first treatment, stimulator, vial and instructions.
Each regular visit: $60 each ($50 cash discount cost)
In-office and phone consultations for 10 minutes: $30.00

Payment due at time of service

I understand and agree that, (regardless of my insurance status), I am responsible for the balance on my account for any professional services rendered. I have read all the information and have completed the forms. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature _____ Date _____

CONSENT TO TREATMENT AND RELEASE OF LIABILITY

I, _____, hereby consent, authorize and request Mark W. Light, M.D.. and/or Vickie Van Scyoc, R.N., to administer the treatment deemed advisable and necessary to my (my dependent's) condition. Furthermore, I have read the rules for treatment and understand that my success in the program relies on adhering to the guidelines for my treatment. Furthermore, I hold Mark W. Light, M.D. and Vickie Van Scyoc, R.N., harmless should any complications occur during the time I (my dependent) am receiving treatments.

Signature of patient (or guardian if patient is a minor) _____ Date _____

Witness: _____ Date _____

INFORMATION RELEASE

I give my consent to Mark W. Light, M.D., Vickie Van Scyoc, R.N., or their associates to use my (my dependent's) diagnosis and treatment data and my (my dependent's) photographs, if applicable, in journals, research or other publishing purposes without revealing my real name and identity.

Patient signature _____ Date _____

Parent/ guardian signature _____ Date _____

COMPLEMENTARY & ALTERNATIVE HEALTH CARE NOTICE

> > > All clients must read, understand and sign this disclosure < < <

Mark W. Light, M.D., N.A.E.T. Certified Practitioner
Vickie Van Scyoc, R.N., N.A.E.T. Certified Practitioner

A) The individual(s) performing N.A.E.T. is (are) Certified N.A.E.T. practitioner(s),
B) N.A.E.T. is alternative or complementary to healing arts services licensed by the state.
C) The services of N.A.E.T. and the therapist(s) that provide N.A.E.T. are not licensed by the state.
D) I (we) am (are) certified through Dr. Devi Nambudripad as Certified N.A.E.T. Practitioners. I (we) have completed Basic and multiple advanced trainings.

I understand that N.A.E.T. is not a medical diagnostic procedure and therefore does not diagnose a disease. Rather, N.A.E.T. gives the practitioner an indication as to the substance(s) to which the patient may have a sensitivity. N.A.E.T. uses various, standard medically proven diagnostic measures and modalities (chiropractic, kinesiological, and Chinese Medicine) to determine the patient's condition. The premise behind N.A.E.T. is to desensitize a patient to a substance(s) using chiropractic, acupressure, nutritional, and kinesiological principles so that the patient may not experience hypersensitive symptoms when they have future contact with them.

I understand that I am (my dependent) to continue all medications and other treatment modalities as they have been prescribed unless otherwise directed by the doctor who prescribed them. During the 25 hours, or after, if I (my dependent) get a life-threatening reaction from the allergen for which I (my dependent) was treated or from some other sources, I need to seek emergency help immediately from a physician qualified in emergency treatments, or by calling 911, or attending an emergency room at the local hospital. If I (my dependent) am suffering from severe allergic reactions to substances, I should consult an appropriate physician and take appropriate medication (such as medication to prevent itching, tissue swelling, fever, cough, pains, infections, mental irritability, violent behaviors, etc.) to keep my (my dependent's) symptoms under control while I (my dependent) am treating with N.A.E.T. treatments. This way essential N.E.A.T. treatments can be completed without interruption, and once I (my dependent) complete the essential N.A.E.T. treatments for my (my dependent's) condition, I (my dependent) may not need to continue pharmaceutical drugs indefinitely.

I understand that for 25 hours after the treatment I (my dependent) am to avoid eating, touching, breathing and coming within 5 feet or more, as was instructed by my practitioner, of the substance(s) for which I (my dependent) am being treated, I realize that the treatment may not work and I (my dependent) may have a sensitivity reaction.

I understand that I (my dependent) must return after my 25 hours avoidance period, preferably within 24 hours but at least within 7 days, to see if I (my dependent) have cleared for the substance(s). I fully understand that I (my dependent) may still experience a reaction to the substance(s) of unknown severity if I (my dependent) come in contact with them if I (my dependent) did not clear them completely. If I (my dependent) did not clear them completely I (my dependent) may be required to repeat the procedure (more office visits at my cost) until I (my dependent) clear them satisfactorily.

I acknowledge that I have read or have had read to me the above statements and I have had an opportunity to ask questions about its content and by signing below I agree to the terms and procedures. I have also been given a copy of this document.

Patient's signature (or guardian of dependent) _____ Date _____

Witness _____ Date _____

Phone number (_____) _____ Email address _____

By entering my email address I agree to receive information and news that these practitioners believe would be of interest to you. ALL your information is strictly confidential.