



MCDONAGH MEDICAL CENTER, INC.

2800-A Kendallwood Parkway - Kansas City, Missouri 64119 - (816) 453-5940

AGREEMENT CONCERNING CHELATION THERAPY

I have described to you in detail the method of administration of chelation therapy using disodium Ethylenediamine Tetraacetic Acid (EDTA); the purpose for its administration in your case; its potential for good and potential harmful side effects. You have indicated a desire to undertake this therapy.

I have advised you that EDTA has been cleared by the Food and Drug Administration for mobilization and reduction of heavy metals (such as lead) from the body where undesirable quantities are present; that, in addition, EDTA is being used increasingly by a minority of physicians for treatment of arteriosclerosis and related conditions; and that this latter usage has been disapproved by medical associations and/or other groups on the grounds that such usage of this substance has not as yet been shown to be "safe" or "effective" or usual, customary and reasonable. Because of such disapproval, and because a majority of doctors do not use it, insurance companies ordinarily refuse to pay for EDTA therapy.

Among the principal side effects which may accompany administration of EDTA therapy are: potential kidney damage (not seen with modern dosage and speed of infusion), nausea and vomiting (very rare), burning or stinging at site of infusion (correctable), hypotension (very rare); hypoglycemia (common if no prior food taken), dermatitis (responding to vitamin B-6), muscular tetany (responding to magnesium), and local thrombophlebitis (very rare).

Whether chelation therapy is "safe" or "effective" for a specific condition depends upon the degree of likelihood of injury from the use of the procedure when properly administered, upon the prognosis for the condition if left untreated, and upon cooperation in the following dietary and rest regime which accompanies the procedure. I believe that in your case chelation therapy is proper under these criteria, and that its use will probably improve the condition for which you are under treatment and your overall health. However, you must understand that I cannot and I do not guarantee or warrant the results in any manner. Furthermore, despite the use of disodium magnesium EDTA for over 30 years in the clinical practice, the term is not justified, however, since it is not standard therapy yet in the United States, I cannot and do not offer this procedure to you except upon the condition that you release me from any legal responsibility for harm resulting from its use in your case. Your signature on this agreement will constitute a full and final release of any legal responsibility resulting from the administration of chelation therapy in your case and/or any other medical treatment that may be necessary as a result thereof.

Edward W. McDonagh, D.O., F.A.C.G.P.

Charles J. Rudolph, D.O., Ph.D.

I HAVE READ AND UNDERSTAND THE ABOVE, under your care for chelation therapy,

Under the conditions indicated, I hereby place myself and agree to the above release.

Dated: _____

Patient _____

WITNESS: _____

RESPONDENT'S
EXHIBIT
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Charles J. Rudolph, D.O., Ph.D.

Nutrition • Allergies • Family Practice • Degenerative Diseases • Preventive Medicine • Metabolic Disorders

CONSENT TO MEDICAL TREATMENT

PATIENT _____ DATE _____

1. I hereby voluntarily consent to treatment, procedures by McDonagh Medical Center, his assistants or his designees as is necessary in the judgment of McDonagh Medical Center.

2. I acknowledge the clinic policy of HIV testing may be done due to the extensive use of venipuncture, both diagnostic and therapeutic. I accept the fact that treatment may be denied on the basis of a positive HIV test.
Signature _____

3. Permission is granted for prescriptions for my family to be packaged in containers without child-resistant safety caps.

4. It has been explained to me and I understand that the vitamin and mineral supplements at the clinic are not generally covered by Medicare or other health insurers.

5. I agree, that if I accept treatment, I shall be responsible for payment of all costs at the time of services.

6. Filing of insurance claims shall be my own responsibility.

7. I understand the above information.

Patient

Signature _____ Date _____

If patient is a minor or unable to consent, complete the following: Patient (is a minor _____ years of age) or is unable to sign because _____

legal guardian/power of attorney _____

Witness _____

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