INFORMED CONSENT FOR CALCIUM EDTA CHELATION THERAPY

I, hereby give consent to **Oaktree Wellness Center** and specifically to **Dr. Thomas F. Drost MD, ND, FACS**, to perform intravenous Calcium EDTA chelation therapy ("Chelation Therapy') for the purpose of treatment of atherosclerotic disease and/or heavy metal toxicity, and/or prevention or treatment of degenerative diseases. I understand that Calcium EDTA is used in this treatment along with certain other additives such as vitamins and minerals. I understand that Chelation Therapy is a standard therapy widely approved for the treatment of heavy metal toxicity and that EDTA is an FDA-approved drug; however, the use of EDTA by my physician for my treatment is what is called "off label" use of the drug. The usage of EDTA is considered controversial for the generalized treatment of atherosclerotic vascular disease and other degenerative diseases, and a minority of the medical community accepts the view that it is of benefit in the treatment of such disorders. Opponents consider such use of EDTA to be "experimental." I am advised that my treating physician believes that Chelation Therapy does have positive clinical benefit. I have been informed that other treatment approaches have been used in these conditions, including but not limited to bypass surgery or angioplasty and these alternatives have been explained to me to my full satisfaction.

I understand that the benefits of Chelation Therapy are much greater if I follow a healthy lifestyle (non-smoking, weight control, proper exercise, proper diet, and nutritional supplementation). I understand that an initial treatment will be given, and further treatments may be necessary. I understand that these treatments may be extended over a number of months. I have been informed that Chelation Therapy may need to be repeated from time to time in the future in order to maintain the benefits. I understand that it is my option to stop this treatment protocol at any time without incurring any further expense after I have directed that such treatment be stopped.

While I understand that there have been no warranties, assurances or guarantees of successful treatment made to me, I desire to undergo this treatment after having considered the information contained in this document, the information provided to me through my conversations with my treating physician and through materials provided to me by the office to educate me about the treatment. I acknowledge that I have had the opportunity to ask any questions of my physician with respect to the proposed therapy and the procedures to be utilized and all of my questions have been answered to my full satisfaction. I also acknowledge that I have received a copy of this signed, informed consent.

Date:_____ _____
PATIENT'S SIGNATURE

_____
PATIENT'S NAME (Printed or Typed)

Date:_____ _____
SIGNATURE OF A RELATIVE
OR REPRESENTATIVE

Date:_____ _____
THOMAS F. DROST MD, ND, FACS

Date:_____ _____
WITNESS SIGNATURE

Date:_____ _____
WITNESS NAME (Printed or Typed)