



# COMPLETE CHIROPRACTIC CARE

**Dr. Olga Roshior**

Chiropractic Physician • Certified Acupuncturist

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## INFORMED CONSENT FOR BAX-3000 ASSESSMENT

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

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

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

**Procedures:** I understand that this is a non-invasive procedure (the skin is not pierced). A metal clip is attached to the skin to measure electrical conductivity on the hands. Homeopathic remedies, nutritional supplements and other natural remedies may be used to bring abnormal electrical patterns into equilibrium. I understand the nature of allergies and related symptoms are of an unpredictable nature and therefore the facility cannot guarantee any results.

Complete Chiropractic Care cannot guarantee that new allergies will not develop in the future and that in some cases allergies and sensitivities do not respond to the treatment. I choose to be tested with the BAX-3000 electro dermal. I understand that electro dermal 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.

**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. 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. I understand that there is a risk factor when desensitizing allergies that sensitivities may increase. I assume all responsibility for the unpredictable immune reactions that may lead to increased symptoms. I agree to seek immediate medical attention should this occur and understand that this facility does not treat cases of anaphylaxis and I agree to completely disclose all information regarding any life threatening allergies or allergies resulting in anaphylaxis.



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**Questions:** I have been provided with the opportunity to ask any pertinent questions I have regarding the BioAllergenix testing procedure, protocol or treatment program.

**Free to Decline:** I understand that I may decline to participate in the BAX-3000 electro dermal testing and can choose instead to have other allergy testing, including scratch test or blood tests for antibodies.

**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 of Services:** You are responsible for the payment of the normal and necessary fees associated with the BAX-3000 and 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 BAX-3000 and my rights and responsibilities and hereby consent to the use of the BAX-3000 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.

Date \_\_\_\_\_

Name \_\_\_\_\_ Signature \_\_\_\_\_

Signature of Parent or Guardian if Patient is a minor \_\_\_\_\_