



Bernhoft Center For Advanced Medicine

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MEDICAL DIRECTOR

GENERAL INFORMED CONSENT ---- Innovative Medicine

This medical practice uses an innovative and integral approach to the myriad of complex factors causing chronic disease. We view an individual's disease process as an imbalance in the complex interrelated components of all systems of the human body. There are many factors involved in the bio-regulatory system including genetic predisposition and vulnerability, physical, environmental, toxic or traumatic factors, psycho-emotional stress and trauma, malnutrition, and spiritual disharmony.

The therapeutic protocols we offer, especially treatments involving the administration of nutritional supplementation, herbal or alternative medicinal products, while derived from extensive scientific data implying hypothetical applications to the treatment of specific disease, in large part may be considered investigational and/or experimental by the FDA or by your insurance company. Even though we use therapies that are supported by extensive observation and data collated by many physicians and investigators, some may lack controlled double-blind studies of medical scientists which objectively delineate the effectiveness of such treatments.

Since many of these therapies must be considered investigational, they may or may not be billable to or reimbursable by third parties.

These therapies are, by nature, relatively non-toxic when administered and complied with properly. However, as with prescription medications, there is always a risk of an untoward, unpredictable reactions or adverse side effects.

While I understand 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 and the knowledge that this clinic utilizes innovative/experimental methods. I acknowledge that I will have the opportunity to ask any questions of my physician with respect to the proposed therapy and the procedures to be utilized.

Signature _____

Date _____

Print Name _____

Name of Patient _____