

Allergy Skin Testing Consent Form

PA Allergy Relief

Patient Name _____ Date _____
File # _____

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 such as allergy scratch tests, blood tests and allergy shots. These have been described to me by the doctor.

Procedures: I understand that this is a non-invasive procedure. A wrist cuff will be placed on either the right or the left hand with a series of sensors that make contact to the skin to measure electrical conductivity. Homeopathic remedies, nutritional supplements and other natural remedies may be used to bring abnormal electrical patterns into equilibrium during the course of my treatment. I understand the nature of allergies and related symptoms are of an unpredictable nature and therefore PA Allergy Relief at Lifeline Chiropractic Inc. cannot guarantee any results. I understand PA Allergy Relief at Lifeline Chiropractic Inc. 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 have chosen to be tested with the LZR7. I understand that this testing has not been scientifically proven to be reliable and that my physician must still rely upon my observation as to the efficacy of the test and any treatment based on the results of the 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 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 into equilibrium, but please report any discomfort you may experience from taking these substances to you your examiner or physician. Please report any significant health problems (diabetes, high blood pressure, ect..) to your physician. I understand that there is a risk factor when desensitizing allergies, and that sensitivities may increase. I assume all responsibility and I agree to completely disclose all information regarding any life threatening allergies or allergies resulting in anaphylaxis.

Questions: I have been provided with the opportunity to ask any pertinent questions I have regarding the LZR7 testing procedure, protocol, or program.

Free to Decline: I understand that I may decline to participate in the ASA Laser System and can choose instead to have other allergy tests, including a scratch test or blood test 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 to participate in this assessment with that understanding. Your physician may need to use other forms of testing in the course of the treatment.

Payment of Service: You are responsible for the payment of the normal and necessary fees associated with the LZR7 session and any remedies, supplements, or herbals recommended as a result of the testing. Your physician may need to use other forms of testing in the course of your treatment.

Name _____ Signature _____ Date _____

Signature of parent or guardian if patient is a minor _____

PA Allergy Relief at Lifeline Chiropractic, Inc.
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