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NAET Treatment Authorization

I certify that Dr. Joan Margaret does not claim to cure any illness or disease with Nambudripad's Allergy Elimination Techniques (NAET).

I understand that NAET is not a medical diagnostic procedure and therefore does not diagnose a disease. NTT (Nambudripad's Testing Techniques), uses various standard medically proven diagnostic measures and modalities (allopathic, chiropractic, kinesiology and acupuncture procedures) to diagnose the patient's condition. NTT gives the practitioner an indication as to the substance(s) to which the patient may have sensitivity. The premise behind NAET is to desensitize a patient to a substance(s) using allopathic, chiropractic, acupuncture/acupressure, nutritional and kinesiological principals so that the patient may not experience hypersensitive symptoms when they have future contact with the desensitized allergens.

I understand that I (or my ward) am to continue all medications and other treatment modalities as they have been prescribed, unless otherwise directed by the doctor who prescribed them. During the 25 hours after a treatment, if I (or my ward) should get a life-threatening reaction from the allergen, or from some other sources, I (or my ward) should seek emergency help immediately. Such help may be from a physician qualified in emergency treatment, or by calling 911 or by attending an emergency room at the local hospital. If I (or my ward) am suffering from severe allergic reactions to substances, I agree to consult an appropriate physician and to take appropriate medication (such as medication to prevent itching, tissue swelling, fever, cough, pain, infections, mental irritability, violent behaviors, etc.) to keep my (or my ward's) symptoms under control while I (or my ward) am in a series of NAET treatments. This way, essential NAET treatments can be completed without interruption.

I understand that for 25 hours after the treatment I (or my ward) am to avoid eating, touching, breathing and coming within 5 feet of the substance(s) for which I (or my ward) have received treatment. If I (or my ward) come in contact with substance(s) for which I (or my ward) am being treated, I realize that the treatment may not work, and I (or my ward) may have a sensitivity reaction.

I understand that I (or my ward) must return after the 25 hours avoidance period, preferably within 7 days, to see if I (or my ward) have cleared for the substance(s). I fully understand that I (or my ward) may still experience a reaction to the substance(s) of unknown severity if I (or my ward) come in contact with them and I (or my ward) did not clear them completely. If I (or my ward) did not clear them completely, I (or my ward) may be required to repeat the procedure (more office visits at my cost) until I (or my ward) clear them satisfactorily.

I have read or have had read to me the above statements and have had the opportunity to ask questions about its contents and by signing below I agree to the terms and procedures.

Patient's Signature Date

Name of Minor Relationship to Ward

Signature of Witness Date