

Consent for Alternative Medical Care Using the BICOM 2000

Client's Name _____ Patient's Name _____

I hereby certify that I am the owner or an authorized agent of the owner for the above named pet and am over the age of eighteen. I recognize that this is a form of treatment for my pet that varies from traditional evidence-based Western veterinary medicine but one that has undergone statistical efficacy analysis. (See www.bicom2000.org/pdf/Brugemann2-e.pdf) This treatment is being pursued _____ a) as a recommendation from my regular veterinarian, _____ b) as a result of a word-of-mouth referral, _____ c) at my own request or _____ d) as a result of a referral from another veterinary or other health care professional. (Please initial one of these.)

I understand that the objectives of bioresonance therapy with the BICOM 2000 are to:

1. treat chronic illnesses;
2. detoxify the effects that chemicals, bacteria, fungi, mold, and heavy metals are having on my pet's body;
3. relieve and/or eliminate my pet's allergies;
4. diminish pain and/or chronic fatigue; and/or
5. help my pet heal faster from injuries or surgical procedures.

The information provided to me is that the diagnostic and/or therapeutic rationale for treatment with this device include the removal of foreign electromagnetic frequencies and the strengthening of healthy internal cellular oscillation patterns. During the medical care procedure, the electromagnetic frequencies of my pet's body will be fed into the BICOM device, modulated by it, and returned through a modulation mat placed over the appropriate anatomical area. This is a pain free form of treatment but one that has been known to provoke occasional detoxification symptoms including rashes, nausea, lethargy, fevers, warmth to the skin under the mat, and/or the activation of a latent disease process that was masked by the body's defenses prior to the administration of this treatment.

I understand that not all patients can or will benefit from alternative medical forms of care and that some treatments may require longer periods of time than others to produce the desired results. I accept that the attending doctor may discuss, recommend, and/or prescribe other modes of care for my pet including referrals to general practitioners, boarded specialists, other alternative medical caregivers, conventional medical or surgical care, or a combination of these options. I also accept that the attending health care provider may decide not to provide suggested BICOM 2000 resonance therapy without further diagnostic testing or because, after a full examination, there is no apparent reason that it would benefit my pet. If the expected response is not forthcoming, it is also possible that treatments may need to be interrupted to pursue additional diagnostic tests.

I will be provided with a medical care plan and written estimate of the fees related to the additional diagnostic testing that may be required as well as the fees linked to treatments using this device. I am aware that the practice of veterinary medicine is not an exact science and, thus, no guarantee for successful treatment has been made. I am encouraged to ask questions and agree not to proceed with this alternative form of care until I have them answered to my satisfaction.

I hereby consent to the provision of the care described above and, in the absence of negligence, agree to hold the attending doctor(s) and/or staff at this veterinary practice harmless for the absence of the desired response to treatment or any ill effects experienced by my pet.

Signature of Owner or Authorized Agent

Date