FAIRPLAY THERAPY CENTER
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NAET® CONSENT FORM

I _____ understand that the Fairplay Therapy Center does not claim to cure any illness or disease with NAET® (Nambudripad's Allergy Elimination Techniques).

I understand that NAET® is not a medical diagnostic procedure and therefore does not diagnose a disease. NTP (Nambudripad's Testing Procedures) uses various, standard medically proven diagnostic measures and modalities to diagnose the patient's condition. NTP gives the practitioner an indication as to the substance(s) to which the patient may have a sensitivity. The premise behind NAET® is to desensitize a patient to a substance(s) using 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 (my dependant) 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 or after if I (my dependant) experience a life-threatening reaction from the allergen my dependant or I was treated for from some other sources, I need to seek emergency help immediately from a physician qualified in emergency treatments, or by calling 911 or attending an emergency room at the local hospital. If my dependant or I am suffering from severe allergic reactions to substances, I should consult an appropriate physician and take appropriate medication (such as medication to prevent itching, tissue swelling, fever, cough, pains, infections, mental irritability, violent behaviors, severe depression, etc.) to keep my dependant's or my symptoms under control while my dependant or I am treating with NAET® treatments. This way essential NAET® treatments can be completed without interruption.

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

I understand that my dependant or I must return after my 25 hours avoidance period preferably within 24 hours but at least within 7 days, to see if my dependant or I have cleared for the substance(s). I fully understand that my dependant or I may still experience a reaction to the substance(s) of unknown severity if my dependant or I come in contact with them if my dependant or I did not clear them completely. If my dependant or I did not clear them completely, my dependant or I may be required to repeat the procedure (more office visits at my cost) until my dependant or I clear them satisfactorily.

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

_____ _____
Patient's Signature Date

_____ _____
Name of Minor Relationship to Dependant

_____ _____
Signature of Witness Date