Declaration of Informed Consent

You have scheduled an appointment for an endobiogenic evaluation with Annette Davis, C.N. Annette is a Certified Clinical Nutritionist and Endobiogenic Practitioner who has studied Clinical Phytotherapy & Endobiogeny with Dr. Jean Claude Lapraz for 20 years. Dr. Lapraz is a French medical doctor and the co-innovator of Endobiogeny.

You must agree to maintain your medical relationship with your regular primary care provider for the purpose of ongoing health maintenance, prevention, evaluation and management of any acute minor or serious medical problems, as well as any pharmaceutical needs that you may have.

It is also important for you to understand that although Endobiogeny has been studied closely and extensively in France, it has not yet been subjected to the requirements of scientific scrutiny by American medical standards. However, since herbs and supplements are available over-the-counter to all Americans, it is our belief that you are serving yourself well by undergoing an Endobiogenic consultation to assist you in selecting the herbal therapy with the greatest potential benefit and the least potential risk for you as a unique individual.

The endobiogenic treatment program will likely involve significant dietary and lifestyle changes in addition to a blend of herbs and supplements. It is important for you to closely adhere to the recommendations to achieve maximum benefit from the program.

I have read and understand the above statements. I agree to proceed with an endobiogenic evaluation at my own discretion, understanding that Annette Davis is ***not*** *an Idaho licensed M.D. or D.O. She will be acting as a consultant to provide natural health care services as defined by and in compliance with Idaho Statutes sections 54-1804. Dr. Lapraz, the co-innovator of Endobiogeny, is a French licensed medical doctor. I understand that Dr. Lapraz is* ***not*** *an Idaho licensed M.D. or D.O. Additionally, I authorize EIMC to share critical information such as lab alerts with my Primary Care Physician, and I authorize my lab data to be used anonymously for research purposes.*

Primary Care Physician Authorized to Receive Critical Information		
Name:	Phone:	Fax:
Address:		

Signature **Date**

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