Murray R. Susser, M.D.
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INFORMED CONSENT

I seek the medical services of Murray Susser M.D. I am executing this consent to confirm my discussion with Dr. Susser and understanding of the risks, benefits, and alternatives to treatment by Dr. Susser.

1. Benefits of Dr. Susser's Approach and Scope of Practice

I understand that Dr. Susser uses diagnostic and treatment methods that—beyond the scope of conventional medicine—are known as preventative, complementary, alternative, functional, or integrative ("integrative"). Integrative medicine focuses on nutritional and metabolic imbalances, diet, exercise, environmental influences and psycho-social stressors based on the premise that they directly relate to the development and maintenance of illness. Integrative medicine evaluates these influences and then specifically tries to remedy them. It encourages patients to give up negative lifestyle patterns and establish more positive ones regardless of the type of medical problems.

2. Risks

I understand that the treatment and modalities employed may be different than what some people consider "mainstream" medicine. I am aware that there is some controversy in the medical community as to integrative medical practices. The potential "risks" of integrative medicine that are asserted by critics in this debate are:

a. lack of sufficient testing to constitute "evidence-based" medicine
b. use of biologically active agents that can present risks when used in conjunction with conventional medical therapies
c. potentially negative biological or psychological effects that have received insufficient testing
d. delay in seeking mainstream treatment based on scientifically unsupported practices
e. use of laboratory tests the value of which other practitioners question.

I understand that, notwithstanding this dispute, Dr. Susser only employs treatments he believes to be safe and effective. In addition, I understand that Dr. Susser at times uses FDA approved medications to treat a different condition than the one specified by the FDA. This is commonly known as "off-label use." I am requesting that Dr. Susser use his judgment in prescribing medications for me that are off-label but which he believes to be appropriate.

3. Alternatives

As alternatives, Dr. Susser encourages me to speak with and consider the advice of other physicians. Dr. Susser will consult with, but is not replacing, care currently provided to me by other physicians, such as my gynecologist, cardiologist, gastroenterologist, pediatrician (in the case of children), oncologist or other specialty care. Dr. Susser has advised me that he does not admit patients to the hospital or treat hospitalized patients, and I understand that I should maintain a relationship with a physician who is available to provide emergent and urgent care. If I encounter a medical emergency

and am not able to obtain care from my physicians, I will contact 911 or report to a hospital emergency department as appropriate.

4. Medication and Responsibilities
I understand that Dr. Susser makes available medications, nutritional supplements and other products for sale to his patients in his office and on his website. I understand that I am not obligated to purchase these products, and can purchase medications, dietary supplements, and other products from any source of my choosing.

I understand that Dr. Susser makes no representations, claims or guarantees that my medical problems or conditions will be helped by undergoing treatment by him. I understand that my failure to comply with any treatment recommendations may impede results.

I am responsible to disclose to Dr. Susser all medication, care, and assessments that I receive elsewhere and to provide medical records from other providers to ensure that care is coordinated and compatible.

I understand that Dr. Susser's treatment may include recommendation that I seek other types of treatment from other health professionals who are not affiliated with him. I understand that Dr. Susser does not supervise these professionals and is not responsible for them.

NOTE: DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING THIS FORM. DO NOT SIGN THIS FORM IF YOU HAVE TAKEN MEDICATIONS WHICH MAY IMPAIR YOUR MENTAL ABILITIES OR IF YOU FEEL RUSHED OR UNDER PRESSURE.

I certify that I have read the foregoing Informed Consent, discussed the issues noted above, had opportunities to ask questions, and agree and accept all of the terms above.

PATIENT NAME: ____

PATIENT SIGNATURE: X______________________________ **DATE:** _________

WITNESS SIGNATURE: X______________________________ **DATE:** _________

I have explained this Informed Consent and answered all questions, and informed the patient of the available alternatives and of the potential risks. To the best of my knowledge, the patient has been adequately informed and has consented.

Physician Signature: ___________________________________ *Date:* _________