HIGH DOSE IODINE PROTOCOL

Request and Consent Date: _____

DRAFT

Dear _____:

After our extensive evaluation and discussions, we invite you to participate in this **HIGH DOSE IODINE PROTOCOL** ("HDIP"). The HDIP is a treatment protocol formulated by Dr. Cheikin ("Physican") based on over ten years of experience utilizing iodine therapeutically as well as extensive reviews of the last 200 years that Iodine has been used. Protocols that are used by holistic medicine to evaluate and treat certain conditions are not the same as those offered by conventional medicine, called the "standard of care". As long as you know the Risks, Benefits and Alternatives (RBA) of a proposed treatment, you can be treated outside the "standard of care" by a licensed physician using approved agents. This document is an Addendum to the General and Holistic Policies and Procedures document(s) that you have already signed (and should review). By signing this Request and Consent you agree that you have reviewed the materials at cohlife.org/iodine and are satisfied that you have had sufficient information and time to make this informed decision. No claims or guarantees of outcome have been made orally or in written form.

Sample Iodine Dose Ranges for reference: While the RDA for Iodine for adults is 0.150 mg, there remain indications for 100 to 1000 mg or more per day.

Conditions that may respond favorably include:

- Thyroid diseases
- Fibrocystic Breast Disease
- Prostate conditions
- Certain cancers
- Chronic and/or recurrent infections of the sinuses, mouth, urinary and GI tracts, skin, and other areas.
- Immune system dysfunctions including some autoimmune diseases
- Hormonal dysfunctions
- Toxicity with Fluoride, Bromide, Mercury, as well as other agents such as endocrine-disrupting chemicals (EDC's)

Potential Benefits of the HDIP:

- Slowed rate of progression of certain conditions
- Improvements or reversal of certain conditions
- Less side-effects compared to conventional treatment(s)

Potential risks of this program:

- Failure of the certain conditions to respond to treatment(s)
- Cost of testing and treatment
- Known and unknown and/or unpredictable interactions between HDIP and conventional treatments (past, present, future) .
- Known and unknown and unpredictable interactions between your individual characteristics and the treatment(s) provided.
- Side-effects, Illness and/or death due to the treatment(s) and/or progression of certain conditions, which can include (but are not limited to) exacerbation of Hashimotos, Graves, thyroid cancer and thyroid storm.

Alternatives to this program:

- "Conventional" treatments for conditions which may include pharmaceuticals, chemotherapy, surgery, immunotherapy and irradiation.
- Other "alternative programs".

Contraindications for participating

- Active or Pending Treatment(s) by other practitioners that may interfere with the protocols
- Inability to implement diagnostic and treatment protocol(s) which are essential for safety or efficacy, which include but are not limited to dietary and lifestyle changes, supplements, medications, food plans and procedures.
- Insufficient resources to support protocol requirements, including time, energy, finances, willpower, and the support of family, friends and employer as applicable.
- Inability to follow-up with medical visits and/or labs

Core Requirements for Participation in This Program:

- Relationship with primary care Physician (and/or specialist serving such role) for emergencies
- Regular communication with primary care Physician (and/or related specialists) to enable continuity in the event of discharge.
- Allow Dr. Cheikin and his assigns to utilize clinical data for reasonable medical purposes such as reports, CQI for protocols, as long as no PHI is revealed (see HIPAA).
- Willing to amend documents and procedures as reasonably necessary to ensure safety and quality.

Requirements for the "Active" Phase of this Program:

- Adherence to a highly structured protocol for at least six months (and which may include pre-existing therapies);
- Lab testing every 2-8 weeks until "stable" as determined by the Physician and documented on the visit summary
- Medical visits every 1-8 weeks until "stable" as determined by the Physician and documented on the visit summary
- Regular communication with Physician's office at a schedule set by the Physician (Staff-Follow-Up Protocol)

Requirements of the "Maintenance" Phase:

- Regular medical visits and lab testing every 3-6 months, as agreed and documented in your visit note(s);
- If not "stable" as determined soley by the Physician, return to "Active" Phase or Discharge to others' care

Discharge

- You agree that upon discharge from this HDIP you will continue care with your Primary Care or other designated licensed Physician or Practitioner.
- You may terminate this program at any time by direct verbal communication with the Physician or certified letter. Email communications may not be used.

Discharge by Physician will occur when you

- Accept treatment(s) by other practitioner(s) or agencies without advance agreement in writing;
- Fail to follow or implement protocol(s) which, in the sole opinion of the Physician renders the treatment ineffective or unsafe (including due to insufficient resources);
- Fail to communicate or visit with the Physician and/or office at a frequency that is set in the visit note(s).

I have thoroughly reviewed the HDIP and I am convinced that for my personal health, the benefits outweigh the risks and alternatives. I therefore request and consent to participate in the program. In consideration of my being able to participate in this program, I agree to release all liability and to indemnify Michael Cheikin MD, Wyndmoor Rehabilitation Associates PC, and their respective affiliated companies, their officers, directors, shareholders, agents including independent contractors, employees, representatives and their successors and assigns, from and against all claims, actions, judgments, cost, expenses, and demand with respect to injury, loss, death or damage to my person or property in connection with my taking part in the above stated program. To the extent that this program meets the criteria for "compassionate care" I also request such care. It is understood and agreed that this release is to be binding on myself, my heirs, executor, administrators and assigns. I certify that I have read the above and understand it. Intending to be legally bound hereby, I make this agreement.

_____ _____

Patient's signature Date Witness