# CLEAR PASSAGE THERAPIES: INFORMED CONSENT

CONDITIONS OF, AND CONSENT FOR TREATMENT: I hereby request and authorize Clear Passage Therapies, Inc. and Clear Passage Therapies of Manhattan, LLC (herein referred to as CPT) and their designated staff to perform therapy on me. I understand that my therapy includes manual (hands-on) therapy to the soft tissues and other structures of the head, trunk, chest, abdomen, low back, hips, pelvis (including urogenital areas) and whatever other areas the therapist believes may relate to my condition. I consent to treatment which will include external and possibly internal vaginal and/or rectal assessment and treatment. I understand internal work may be necessary in order to access certain ligaments, muscles, structures, joints, adhesions and fibrotic tissues which may affect my condition. I understand I will be informed of any internal assessment and treatment prior to initiation of same, and that I may refuse any suggested treatment at any time.

I will be treated in a private treatment room by a therapist certified in the Wurn Technique®. CPT understands my comfort level is very important to me. While CPT therapists are not physicians, they follow ethical guidelines of American Medical Association (AMA) and American College of Obstetrics and Gynecology (ACOG) regarding patient draping and right to chaperone. I will always have access to draping, including a gown and blanket, plus sheets and/or towels.

I understand CPT conducts research and training in their methods. Notwithstanding other privacy policies I have signed, I consent that data from my case, history, and outcomes, may be reproduced and published in any form by CPT, any related entity, any media or any healthcare journal, so long as CPT maintains anonymity and confidentiality of my Protected Health Information (PHI). CPT may request that students of their work observe and possibly co-treat me. I understand that these are healthcare professionals licensed by their state's or country's appropriate oversight agency. I may accept or refuse observation and co-treatment at any time, without any effect on my treatment at CPT.

POTENTIAL RISKS AND SIDE EFFECTS: For most patients, side effects from this treatment have been transient and minimal, such as temporary minor soreness of the treated areas, soreness in other areas of the body following treatment, possible spotting for women after internal treatment, and fatigue. CPT strongly discourages daily long-distance driving during intensive therapy week, due to fatigue after therapy, extended sitting and stress on the body. We encourage local lodging. Patients with soreness have found relief with ice, over-the-counter anti-inflammatory medication (e.g. ibuprofen) or Epsom Salt baths. I understand, for some patients (due to inflammation, prior trauma, etc.) therapy may cause discomfort, mild pain or emotional distress. Significant pain, lymphedema, infection, or emotional distress after therapy are rare. All of my questions have been answered by CPT. By signing below, I certify that I have discussed all of my underlying medical conditions with CPT therapists.

Since treatment may exacerbate an active infection, I agree to notify my therapist(s) if I contract an infection. Therapy will be discontinued pending medical clearance to continue. If I receive a test or diagnosis showing an infection or acute flare-up before therapy, I will consult a Clear Passage therapist before I attend.

Due to pressure changes in airplanes during flight, approximately 10% of patients report difficulty flying immediately after therapy. We suggest patients not fly for at least 24 hours after 20 therapy hours; and 48 hours after 30+ therapy hours.

Regarding some specific conditions, I understand that:

Patients with a history of either blocked fallopian tubes or tubal disease may be at increased risk of ectopic pregnancy if they become pregnant after treatment. Ectopic pregnancy can lead to serious complications, including death. I agree to discuss with my physician the possibility of increased risk of ectopic pregnancy due to any fallopian tube history. If I have a history of blocked fallopian tubes or fallopian tube disease, I will notify my physician immediately if I become pregnant.

Patients with dilated fallopian tubes or hydrosalpinx: ACOG Practice Bulletin #104 (May, 2009) recommends a prophylactic course of antibiotic for HSG procedures on women with dilated tubes (hydrosalpinx), to decrease the risk of pelvic inflammatory disease (PID). For this reason, CPT requires me to take an antibiotic during therapy. [For patients completing treatment in 5 days, begin the doxycycline (100mg 2x/day) the day before CPT treatment, continue for 10 consecutive days. For patients completing treatment over more than 5 days, take 1-500mg azithromycin the day of CPT treatment, every day of CPT treatment, unless otherwise directed by your physician.]

Intestines can be adversely affected by external forces, such as surgery, adhesions, or radiation therapy. If my intestines have been compromised, I know they could conceivably open or rupture at any time without therapy, before, during or after therapy or during home follow-up. Such an occurrence would cause serious complications, including emergency surgery or death. If I experience serious symptoms at any time, I agree to undergo immediate evaluation by my physician, or an emergency room physician. Endometriomas are delicate structures that could rupture with manual therapy. While rare, such a rupture could spill blood and by-products into the body, resulting in inflammation or infection which would require medical intervention and/or possible surgery.

Cancer is a contraindication to our therapy due to potential risk of spreading the condition, which could become debilitating or life-threatening. If I have a history of cancer in the last 18 months, I must provide CPT with a physician letter specifically clearing me for deep manual therapy.

Patients with a history of edema, lymphedema, radiation therapy, or lymph node resection have an increased risk of developing edema or lymphedema following deep manual therapy. CPT is unable to predict this risk for any patient. Since early intervention improves my chances of edema/lymphedema being a short-term effect rather than a chronic situation, I agree to contact my physician if I note increased swelling in my abdomen or extremities after therapy. If I have a history of edema/lymphedema, I will wear my compression garments while traveling to and from therapy, and after each treatment session.

Intrauterine Device (IUD) could rupture the uterus with manual therapy. CPT requires removal of IUD prior to therapy.

I agree to remain attentive to my condition and notify my therapist immediately if I experience any of the *following:* severe abdominal pain, persistent bleeding, fainting, dizziness, lightheadedness, or shortness of breath, accompanied by weakness, loss of color, or severe abdominal pain, fever, nausea or vomiting. Should these persist, I will seek emergency medical help to rule out serious or life-threatening conditions.

THERAPY AND OVARIAN STIMULATING MEDICATIONS: CPT does not feel it is appropriate to treat patients who are a) actively taking ovarian stimulating medications, or b) will be starting them within two weeks of completing therapy. If I am planning a medicated IVF or ART cycle, I will complete therapy at least 14 days before starting ovarian stimulating medications. Requested exceptions are made on a case-by-case basis a) only by a physical therapist, and b) only for women who spread therapy sessions over several weeks.

THERAPY PROGRAMS: Based on results in published studies, the complete program to treat adhesions, infertility, pain, and bowel obstruction are a minimum of 20 hours. While most patient generally respond well within 20 hours, some may require additional hours, depending on duration and complexity of surgical and traumatic history. Each "treatment hour" consists of 45-50 minutes of treatment in the room with my therapist(s) plus time for my therapist(s) to review my case, consult my chart or other therapists, and to complete my clinical notes. Therapy sessions generally start 5 to 10 minutes after the hour to allow for pre-therapy chart review. Therapy ends five minutes before the hour to allow the therapist to complete the notes on your session.

RESULTS NOT GUARANTEED: Like most health care procedures, the results of this treatment procedure cannot and have not been guaranteed and I have been given no promises with respect to the effectiveness of the treatment procedure. While CPT has published promising research, scientific evidence that the Wurn Technique® reverses infertility or improves organ function is limited to the published literature. I understand that some methods used by Clear Passage are proprietary and protected by trade secret rights. I will not be taught proprietary methods, and I will not use nor share Clear Passage's intellectual property with others.

PHYSICIAN SCREENING: I understand Clear Passage therapists are not physicians. By signing below, I assert 1) I have given complete and accurate information about my medical history to my physicians and CPT, and 2) I have been cleared by my physician(s) for any condition that could be contraindicated for treatment, and 3) if I receive new medical care beyond what I reported, I will notify CPT at once and provide full records for their review, to ensure I can be treated safely.

POSSIBLE CONTRAINDICATIONS include but are not limited to: surgery or post-surgical complications within 90 days prior to therapy, cancer, blood clotting disorder, immune disorder, abnormal cysts, abnormal bleeding, active infection or inflammation, HIV, endometrioma, lymphedema, IUD and any condition which may be exacerbated by deep manual therapy to the soft tissues, organs, bony or ligamentous structures of my body, head, chest, back, abdomen, pelvis, hips, arms, and legs.

THERAPIST TRAINING: I understand that CPT staff contains licensed physical or physiotherapists, physical therapy assistants and massage therapists, none of whom are or claim to be a physician authorized or licensed to diagnose medical conditions nor to practice medicine. I understand that their experience, training and education is limited to that required of their respective professions in the state in which they practice. As a result, the healthcare professionals and staff of CPT do not and cannot provide medical care, oversight and/or supervision.

WISH TO UNDERGO TREATMENT: Having been advised and having the general understanding of the treatment procedure and the potential risks involved, under all the surrounding circumstances, I wish to undergo the procedure above-described.

FOR ADULT PATIENTS: I CERTIFY THAT I HAVE READ THE CONTENTS OF BOTH PAGES OF THIS DOCUMENT. I UNDERSTAND THE BASIC NATURE OF THE PROCEDURE AND THE RISKS INVOLVED. I DO NOT DESIRE ANY FURTHER EXPLANATION AND MY SIGNATURE STATES MY AGREEMENT. ALL BLANKS OR STATEMENTS REQUIRING INITIALS, INSERTION, DELETION OR COMPLETION WERE FILLED IN OR CROSSED OUT BEFORE I SIGNED.

Patient signature date

FOR MINOR PATIENTS: I CERTIFY THAT I HAVE READ THE CONTENTS OF BOTH PAGES OF THIS DOCUMENT. I UNDERSTAND THE BASIC NATURE OF THE PROCEDURE AND THE RISKS INVOLVED. I DO NOT DESIRE ANY FURTHER EXPLANATION AND MY SIGNATURE STATES MY AGREEMENT. ALL BLANKS OR STATEMENTS REQUIRING INITIALS, INSERTION, DELETION OR COMPLETION WERE FILLED IN OR CROSSED OUT BEFORE I SIGNED. I ALSO UNDERSTAND IT IS THE POLICY OF CLEAR PASSAGE PHYSICAL THERAPY TO REQUIRE A PARENT OR LEGAL GUARDIAN BE PRESENT IN THE TREATMENT ROOM AT ALL TIMES DURING THERAPY ON A MINOR CHILD. I CERTIFY THAT I, OR ANOTHER PARENT OR LEGAL GUARDIAN WILL BE PRESENT IN THE ROOM AT ALL TIMES DURING THERAPY ON MY MINOR CHILD.


Parent/Legal Guardian signature date