



*In cooperation with  
Idaho State University Integrative Health Clinic*

## Document of Understanding

You have been referred to the Endobiogenic Integrative Medical Center (EIMC) for assistance in gathering information for the Endobiogenic evaluation you are seeking. Dr. Bokelmann has agreed to evaluate you for this purpose. **In this capacity, Dr. Bokelmann is serving as an Endobiogénie specialist rather than assuming the role of your primary care physician.** Due to very limited appointment availability, it is important that you maintain your medical relationship with your regular primary care provider for the purpose of ongoing health maintenance and prevention and for evaluation and management of any acute minor or serious medical problems. If you do not have a primary care provider and are seeking one in southeastern Idaho, Dr. Bokelmann will be happy to refer you to a suitable provider who would be supportive of your use of adjunctive phytotherapy.

It is also important for you to understand that although the Endobiogenic concept 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 herbal therapy is available over-the-counter to all Americans, it is Dr. Bokelmann's 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 statement. I agree to proceed with an Endobiogenic evaluation at my own discretion, understanding that Dr. Bokelmann will not be acting as my primary care provider. Additionally, I authorize EIMC to share critical information such as lab alerts with my Primary Care Physician, and I authorize my lab results to be used anonymously for research purposes.***

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

**Patient's Signature**

**Date**