Consent Form

Documenting The Effect of Measured Yoga Based Therapy on Disease/Disorder Conditions

Principal: C. Rajan Narayanan PhD, Life in Yoga Institute

Medical Director: <insert name of physician, if any>

Telephone number: 301-328-3845 (Narayanan)

Email Contact: Rnarayanan.us@gmail.com

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1) Introduction

Yoga therapy is conducted at _____ clinic for your abnormal condition under the direction of Dr. Narayanan (and your physician, if present). Taking part in this is entirely voluntary and supplemental to your conventional treatment. Yoga Therapy is not part of the Standard of Care in the United States and participants choose this therapy option at their own risk without any confirmed recommendation of the mainstream medical community. Dr. Narayanan is a researcher and not a licensed physician.

2) Why is this being done? Are there any benefits?

Life in Yoga Institute is perhaps the only provider of yoga who has been certified by the American Medical Community to teach physicians. (See http://lifeinyoga.org/App_Downloads/Accreditation_Certificate.pdf) Scientific studies conducted all over the world, with over 6,000 logged papers recorded in the digital library of the National Institutes of Health (Pubmed) suggest yoga (including meditation) can help different diseases/disorders. Such scientific studies are usually done with a single treatment protocol for the same disease and on average most people are benefitted, but not necessarily everyone to the degree of complete benefits. However, we do Measured Yoga Therapy, which enables customization for each person, while also providing immediate validation of whether it is working or not. Documenting and validating our observations for a large number of patients for this technique developed by Life in Yoga Institute and developing a viable model for medical practices, and using this information for teaching the medical community is our intent. We expect substantial benefits in managing your conditions and the possibility of finally reversing the condition. If in the remote chance that we cannot help you, it will most likely be known right in the first meeting when measurements are taken.

3) Is there any cost to participate?

Yes, this is not covered by any health insurance or any grant. There are three ways one can normally participate, while for those outside the Washington DC metro area the last choice may be the only viable option unless a local person takes responsibility for follow-up:

- Either by payment of $2,500 with up to 12 scheduled meetings, over 8 to 12 weeks, that **provides 100% money-back guarantee** if you don't feel better after keeping all the follow-up appointments. [If you miss any appointments the refund will not be given.]
- OR pay $350 that will cover the cost of the initial visit with no guarantee.

In addition to these costs, additional follow-up consultation will be $200 per visit. **And also at the end of the first visit, if you are told we cannot help you, no fee is charged.** Also those wanting a single bio-meridian reading can obtain one for $60 each time.
All other costs that are part of your physician's standard of care, if applicable, are expected to be covered your medical insurance.

4) <u>What is involved in this program? Testing, practices, weekly appointments?</u>

If you choose to take part in this program, you will begin by signing and agreeing to this consent. At that time you will have some baseline tests done or records from your doctor may be obtained, which may include among other things: (a) examination of vitals; (b) recording of medical history and lifestyle information; (c) Bio-meridian measurements. In addition, if needed and permitted by your insurance coverage, it will be in the discretion of your personal physician to consider ordering additional tests.

Some of the above noted data measurements may not be obvious or known to you, although most (vitals and medical history) should be familiar from past experiences.

Bio-meridians are measured by Bio-well (Electro-Photonic Imaging). This instrumental procedure is not painful or intrusive in any way. Each finger is place on a glass plate with a circular electromagnet below the glass around the finger. The interaction as the electromagnet fires results in electrons flying out of the finger that provides a photonic image. While no side-effects are known from this reading and based on many years of use in Russia we believe it should be safe, being relatively new in the United States there are no validations of the safety from any credible or certifying authorities. At your personal discretion and absorbing risks, if any, unknown at this time, you may voluntarily choose to be evaluated by this instrument.

As noted earlier, we will seek your cooperation to complete demographic and medical information. The clinicians, by your consent here, may collect historical information from your medical chart from your physician, which could include general health history information, demographic information, past health history that are pertinent, like other abnormal conditions.

Following is a summary table of what you will experience:

1.	First Step	Agreeing to participate with understanding of the requirements by signing this consent form.
2.	At that time or Immediately Thereafter	Baseline evaluations taken or extracted from physician records: (a) examination of vitals; (b) recording of medical history and lifestyle info; (c) Bio-meridian measurements.
3.	Regimen begins	First week one or two 60-minute sessions, then 5 to 10 follow-up visits over 8 to 12 weeks. In each visit most likely two Biowell readings would be done – upon arrival and after a practice – unless follow-up is by video call.
4.	End of Period Evaluations	Same as baseline evaluations
5.	Later follow-up	While the program ends after 8 to 12 weeks, past experience suggests that further improvement is possible. Three months later, another follow-up may be scheduled.

<u>Daily Practices</u> to be followed will be instructed and followed-up weekly. These yoga exercises may include breathing, posture, vibrations, affirmations and meditation. After the first week of training, that will involve one or two supervised sessions, you will be guided once a week for a few weeks, and if appropriate for you then further follow-up may be scheduled for alternative weeks with any final tests at the last meeting. You are expected to perform the yoga routine at home every day without supervision. The yoga (including meditation) routine will consist of at least two practice routines each day requiring a total commitment of about one hour each day. The specific routines will be done at your pace and your comfort. In addition to the

commitment of one hour per day for the exercises, you will have an additional commitment of each weekly or bi-weekly appointment. Initial visit will be about 2 hours long.

Scheduling - While your baseline test will be individually conducted for you, the yoga instructions may be in groups – time and day of week (weekday or weekend) determined by mutual convenience of majority of the participants. Within what is feasible, we will try to keep the timings most convenient for you.

5) What are the risks of participating in this program and who takes responsibility?

Participating in this program should not pose any risks that are not ordinarily encountered in daily life. However, if you experience any discomfort, we suggest that you stop the exercise/routine and seek the advice of the principal or medical director. **In general, yoga must be done without stress in the system. As long as you observe that rule, there should not be any need for concern.** Above all, it will be your responsibility to disclose that you are planning a yoga regimen to your physician and ensure you have been guided on any specific do's and don'ts.

Every effort will be made to keep your information confidential – See Section 6. However, there is some risk of loss of confidentiality. For example, someone may observe you participating in this program, especially if the instructions may be done in small groups of participants, or it is possible that data could be stolen although we will seek to keep it secure. The principal (and medical director if present) will make every effort to protect your confidentiality but this cannot be absolutely guaranteed.

Other than the responsibility for health information protection which is borne by the principal/s, rest of the responsibility is entirely with you. Life in Yoga Institute and the program principals do not accept any liability towards your participation in this program.

6) How will my privacy be protected?

Federal laws require that researchers and health care providers protect the privacy of information that identifies you and relates to your past, present and future physical and mental health or conditions, or the provision of health care. If you agree to participate in this program, protected health information will be used and shared with others for purposes of the program. Below is more detailed information about how your health information will be shared and protected. Your information will only be used or shared as explained in this authorization form.

Your physician will be the only others who will obtain your individual health information from your records, and once recorded as part of the test, whatever is included will be available to the entire program team.

All of the tests in this program other than Biowell (Electrophotonic Imaging) readings, if needed, would have been done as part of your regular care. These test results will be used both to develop a customized program and to complete the documentation of this program. These program results may be included in your medical record, since except for the yoga component and Biowell readings the rest of the examinations and tests would likely be covered by your health insurance.

If results of this program are reported in journals or at scientific meetings, the people who participated in this program will not be named or identified. Life in Yoga Institute or the program team will not release any information about your research involvement without your written permission, unless required by law. Once your health information has been disclosed to others outside of our team, Life in Yoga Institute or your physician, the information may no longer be covered by the federal regulation that protects privacy of health information.

Not signing this form or later canceling your permission will not affect your health care treatment outside the program, payment for health care from a health plan, or ability to get health plan benefits.

This Authorization does not have an expiration date.

To cancel your permission, you will need to send a letter or email to Dr. C. Rajan Narayanan stating that you are canceling your authorization. This letter must be signed and dated and sent to this address: 1111 University Blvd West, #1306, Silver Spring, MD 20902; or emailed to RNARAYANAN@GMAIL.COM.

7) What are my options?

You do not have to participate in this program if you do not want to**.** Should you decide to participate and later change your mind for any reason, you can do so at any time.

8) Can I be taken off the program?

The Principal (or the Medical Director) can decide to withdraw you from the program at any time. You could be taken off the program for reasons that relate to your well-being or because the entire program is stopped for any reason.

9) Problems or Questions

The Principal (and Medical Director, if present) noted at the head of this document can provide further information on this program and your participation. If you have any problems, you can report this to either one of them.

Your Contact Information:

Name: _____

Address: _____

Email: _____

Daytime Phone: _____;Mobile Phone: _____

If you agree to participate in this program and absolve all parties of the risks of participation in this program, please sign below after filling the contact information above:

_____ _____

Subject's Signature Date

_____ _____

Name (printed) and Signature of Person Obtaining Consent Date

Volunteer Disclaimer Form

Indemnification of Voluntary Resources for Yoga Therapy

I, _____ of
Full Name (printed)

_____ hereby
Address (printed)

agree to indemnify and hold harmless all the volunteers supporting Life in Yoga Institute in its yoga therapy efforts and space providers (individuals or organizations) who provide the space at no cost.

_____ _____
Subject's Signature Date

Participants Primary Physician Information

Name of Primary Care Physician:

Phone:

Fax:

Email: