Statement of Necessity for the use Alpha-Stim®

Date:_____

I agree to the use of an Alpha-Stim® electromedical device complete with accessories for patient listed below to use at home or in office as a conservative method of treating pain, anxiety, depression and/or insomnia. This technology is supported by successful outcomes documented by more than 80 published articles (see www.mybrainchemistry.com for annotated abstracts). It has shown to be consistently effective so I have advised the patient to utilize it on a regular basis.

Patient Name: _____

Address: _____
_____
_____

Telephone: _____

Email: _____

Practitioner's Signature:

_____

State License Number:

_____

After Completion Fax it to Don Grothoff c/o HIPAA Secure Fax 888-979-6320