IN THE MATTER OF	*	**BEFORE THE MARYLAND**
PAUL VICTOR BEALS, M.D.	*	**STATE BOARD**
Respondent	*	**OF PHYSICIANS**
License No. D25922	*	**Case No. 2001-0433**

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CONSENT ORDER

PROCEDURAL BACKGROUND

On January 2, 2004, the Maryland State Board of Physicians (the "Board") charged Paul V. Beals, M.D. (the "Respondent") (D.O.B. 4/15/1943), License Number D25922, under the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("H.O.") § 14-101 et seq. (2000 Repl. Vol., 2002 Supp.).

Specifically, the Board charged the Respondent with violating the following:

H.O. § 14-404 Denials, **reprimands, probations, suspensions and revocations – Grounds.**

(a) *In general* – Subject to the hearing provisions of §14-405 of this subtitle, the Board, on the affirmative vote of a majority of its full authorized membership, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:

(4) Is professionally, physically, or mentally incompetent, and

(18) Practices medicine with an unauthorized person or aids an unauthorized person in the practice of medicine.

On April 7, 2004, a conference with regard to this matter was held before the Case Resolution Conference (the "CRC"). As a result of negotiations entered into after the CRC, the Respondent agreed to enter into this Consent Order, consisting of Procedural Background, Findings of Fact, Conclusions of Law, and Order.

SUMMARY OF PRIOR DISCIPLINARY ACTIONS

Case Number: 85-0081

A. 1988 Agreement - On June 21, 1988, in resolution of charges[1] issued against the Respondent, the Board[2] and the Respondent executed a non-public Disposition Agreement /Consent Order (the "1988 Agreement"). The 1988 Agreement required that the Respondent follow certain terms and conditions including limiting the use of non-traditional medical treatments, i.e. intravenous chelation therapy[3], Laetrile, Indican tests and xanthine oxidose analysis for patients. The Respondent was also prohibited from providing medical or psychiatric services to psychiatric patients and placing advertisements without Board approval. The Board also ordered peer review of the Respondent's medical practice. (See Exhibit 1, attached hereto and incorporated by reference herein).

B. 1993 Consent Order - On October 23, 1991, the Board voted to charge the Respondent with violation of the 1988 Agreement. The Board's vote to charge occurred prior to the Respondent's eligibility to petition for termination of probation pursuant to the 1988 Agreement. A peer review of twenty-four patients revealed that the Respondent: performed Indican tests without medical indication; provided thyroid medication without diagnostic testing; in the case of normal tests; performed cortisol

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[1] Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. (4), (11) and (18). Codified in 1987 as H.O. §14-504 (4), (11) and (18), later amended by Ch. 109 § 1, Acts 1088, effective July 1, 1998 as H.O. §15-504 (a) (4), (10) and (17), and presently codified as H.O. § 14-404 (a) (4), (10), and (17) with substantive language unchanged from the 1987 codification and the July 1998 amendment.

[2] The Commission on Medical Discipline of Maryland was the predecessor agency to the Board of Physician Quality Assurance which was created when the 1988 General Assembly, by Senate Bill No. 508 and House Bill No. 855, merged the functions of the former Commission on Medical Discipline and the former Board of Medical Examiners into the Board of Physician Quality Assurance. As of July 1, 2003 the Board is now titled the State Board of Physicians.

[3] The Respondent would be permitted to use non-traditional chelation therapy if the FDA double bind testing then in progress showed medical benefits to patients.

testing and prescribed steroids without any medical justification; instituted testosterone therapy without medication; and performed FSH testing without medical indication. The peer reviewers also noted that the Respondent's medical record documentation and record maintenance was inadequate. The charges were resolved in a November 10, 1993 Consent Order which suspended (and immediately stayed the suspension) the Respondent's license for three years, required three years probation with specific terms and conditions, including, but not limited to requirements: to not perform or order tests which were not medically indicated; and to provide complete disclosure (including Board-approved materials) to patients who seek alternative medical treatments. (See Exhibit 2 attached hereto and incorporated by reference herein). The order also contained a cease and desist provision, required appropriate documentation in and maintenance of patient medical records, and ongoing periodic peer review. [4]

C. 1996 Modified Order - On July 26, 1996, a Modified Consent Order (the "1996 Order") was executed granting the Respondent's request to perform chelation therapy provided that all patients sign a Board approved consent form. (See Exhibit 3, attached hereto and incorporated by reference herein).

D. 1999 Modification by Consent to Order - On February 24 1999, the Board again charged the Respondent with violation of probation. The new charge resulted from a December 21, 1998 peer review, which revealed that the Respondent had: inappropriately used FSH testing to assess effectiveness of plant-derived HRT (hormone replacement therapy) and that this testing was not within the standard of care for monitoring HRT. In addition, the peer reviewers found that the Respondent

[4] On June 5, 1995, the New Jersey State Board of Medical Examiners, in a reciprocal action, suspended the Respondent's medical license for three years.

overutilized FSH testing on the sixteen patients whose records were reviewed. On October 20, 1999, and prior to the issuance of a formal charging document, the February 1999 charges were resolved in a Modification By Consent to Consent Order, (the "1999 Order"). (See Exhibit 4, attached hereto and incorporated by reference herein). The 1999 Order, among other things: prohibited the Respondent from performing FSH testing in his office laboratory; required the Respondent to provide a Board-approved disclosure form to all patients for whom he prescribed plant-derived or non-prescription HRT; prohibited the Respondent from using FSH testing to test effectiveness of HRT (with the only exception being determination of the onset of menopause); mandated additional peer review or chart review by a Board designee to ascertain FSH testing ordered for patients after the effective date of the order, and probation was to continue pending successful completion of a peer review of the Respondent's practice.[5]

FINDINGS OF FACT

Case Number 2001-0433

1. At all times relevant to these charges, the Respondent was and is a licensed physician in the State of Maryland. The Respondent was initially licensed to practice in Maryland on December 19, 1980, being issued License Number D25922.

2. The Respondent's business address is 9101 Cherry Lane, Laurel Maryland, 20708. At the time of the incidents described herein, the Respondent did not have hospital privileges in Maryland.

3. The Respondent is board certified in family practice.

[5] The most recent peer review of the 1999 Order is pending.

4. The facts that led to the charges set forth herein result from, among other things; the Respondent's employment as a medical director by Innovative Medical Clinics, Inc., ("IMC") and from the medical care of certain individuals in his private medical practice.

5. IMC, a Maryland corporation, is located at its primary place of business, 19650 Clubhouse Road, Suite 106, Gaithersburg, Maryland 20886.

6. IMC was formed to provide ultraviolet blood irradiation ("UBI") treatment to the center's clients. In routine medical practice UBI is performed for certain diseases, after the patient is treated with chemotherapy. IMC provided a limited treatment; running blood through an ultraviolet light and returning the "treated" blood to the patient. The Respondent, at the time of the incidents described herein, was the contracted Medical Director of IMC.

7. As IMC's contracted Medical Director, the Respondent was assigned the following "duties and responsibilities to exercise as he sees fit:"

(a) participate as a member of the Board of directors of IMS[6];

(b) oversight of all of IMC's[7] medical operations;

(c) review written clinical procedures; approve of all protocols;

(d) review of patient records and monitor progress, as needed;

(e) determine which patients need to be examined by a physician;

(f) write physicians orders and prescriptions;

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[6] Innovative Medical Services ("IMS") was the first name of the company incorporated to provide UBI treatments to clients. The contract indicates IMS and IMC are related corporations. However, both corporations bind the Respondent by contract.

[7] IMS and IMC are used interchangeably throughout the written contract.

(g) make occasional visits to the Clinic to assure medical operations are appropriate;

(h) perform other duties as may be needed by the clinic, and

(i) to be available for telephone consultation and to authorize protocols in relationship to treatment regimes."

8. The Respondent's "optional duties", pursuant to the IMC contract, included: "participate in research grants and other programs with IMS/IMC and the Foundation for Blood Irradiation, and, may refer patients to IMC for UBI treatments."

9. The Respondent delegated his physician duties and the practice of medicine to William Eberlin[8], an unlicensed individual. Mr. Eberlin, a renal dialysis technician, was known as the "Director" at the IMC clinic by the patients seeking health care and treatment.

10. In October 1998, Mr. Eberlin, with the assistance of the Respondent and others, purchased two UBI devices (the "Devices")[9] from the Foundation for Blood Irradiation (the "Foundation") located in Silver Spring, Maryland.

11. At the time IMC purchased the Devices, the Devices were not approved by the Federal Food and Drug Administration (the "FDA") for use on humans or for investigational device exemption and were eventually seized by the FDA in August 2000.

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[8] On May 30, 2001, the Board charged with Mr. Eberlin with a violation of H.O. §14-601, practicing medicine without a license. Mr. Eberlin entered into a Consent Order with the Board on August 12, 2001 in which he admitted that he practiced medicine on patients. Mr. Eberlin was fined fifteen thousand dollars ($15, 000) for practicing medicine without a license.

[9] Precision Assembly Corporation manufactured the devices according to documentation provided by the Respondent.

12. On February 13, 1997, the federal government filed a complaint in the United States District Court for the District of Maryland for Forfeiture *in Rem* of the Knott Hemoirradiator Device (the "Federal Complaint"). [10]

13. A Device was seized on February 20, 1997 from the Foundation's offices in Silver Spring, Maryland. The parties entered into the Consent Decree of Condemnation and Permanent Injunction on January 28, 1998.

14. The Foundation Director, C.S.[11] communicated regularly with the Respondent and Mr. Eberlin about the status of the Device after the Federal Order was entered in January 1998.

15. IMC and the Respondent routinely advertised, via circulation of private offering memoranda, printed pamphlets and word of mouth advertisements, the availability of the UBI treatment and misrepresented that Mr. Eberlin was qualified to provide the treatments.

16. On May 2, 2000, the FDA Consumer Safety Officer ("FDA Officer") visited IMC at 19650 Club House Road, Suite 106, Gaithersburg, Maryland 20886.

17. Upon arrival at IMC at 2:00 p.m., the FDA officer observed two patients in a room, connected to intravenous tubing and having blood pumped from their bodies through tubing into a tabletop Device. The Device was used without FDA or other regulatory approval.

18. The patients connected to this device were monitored by a female identified as a "nurse"[12] ("Ms. G"), who is another unlicensed individual, and Mr. Eberlin.

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[10] The case, brought by the FDA on behalf of the United States is styled *United States of America vs. Knott Hemo Irradiator, Civil No. AW-97-448.* It appears that the Foundation business was transferred to IMC in the fall of 1997.

[11] Mr. S is deceased.

19. During the May 2000 inspection, a Maryland licensed physician was not present on the IMC clinic premises while the two patients underwent UBI treatment.

20. The FDA Officer issued an FDA-48 "Notice of Inspection" to Mr. Eberlin and provided his FDA identification credentials. Mr. Eberlin represented to the FDA Officer that he was not a medical doctor, but a certified hemodialysis technologist.[13]

21. Mr. Eberlin explained to the FDA Officer that UBI treatment sessions cost one hundred and twenty dollars ($120.00), were sixty minutes in duration and were given to treat patients' diagnosed disease processes.

22. According to Mr. Eberlin, the UBI treatment procedure consisted of removing 200 cubic centimeters (200 cc)[14] of the patient's blood into tubing, passing the blood through the Device; the blood was then re-transfused into the patient. Heparin, a prescription blood anticoagulant, was injected to prevent the blood from clotting in the tubing during this process.

23. Mr. Eberlin provided a copy of the operating procedure for the Devices, yet refused to provide the Device's shipping records and product labeling.

24. The FDA Officer reported his findings to the Board Compliance Unit.

25. On June 15, 2000, Board staff met with and interviewed Mr. Eberlin. The Board staff found Mr. Eberlin at the IMC address. The IMC office and treatment area lacked signage markings on all doors and areas inside and outside of the main building.

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[12] The "nurse" is not a practical or registered nurse licensed in Maryland.

[13] According to Maryland law, hemodialysis technicians are licensed as certified nursing *assistants* ("CNA's") by the Maryland Board of Nursing. Hemodialysis is a medical treatment delegated to licensed nurses acting under the supervision of a physician. The hemodialysis technician (a nursing assistant) acts under the supervision of a registered nurse.

[14] The amount of blood removed and reinfused into the patient is approximately a one-cup volume.

26. During the June 15, 2000 meeting, Mr. Eberlin stated he was a dialysis technician. that he learned how to use the Device on the job, and, was assisted by Ms. G.

27. Mr. Eberlin explained to Board staff that he met with each patient before the UBI treatment to take a medical history, vital signs and perform a physical assessment.[15]

28. Mr. Eberlin represented that IMC's patient population included patients diagnosed with HIV, Hepatitis C and Non-Hodgkin's lymphoma. The UBI treatment, according to Mr. Eberlin, removed or destroyed any viruses or bacteria in the blood.

29. Mr. Eberlin represented that a physician was not employed by IMC to provide the UBI treatments, as it was "not necessary".

30. On August 3, 2000, the Board issued, via certified mail, return receipt requested, a Cease and Desist Order commanding Mr. Eberlin to cease and desist the operations of IMC for violating § 14-601 of the Maryland Medical Practice Act because he and the clinic employees were practicing medicine without a license. Mr. Eberlin signed the return card for the certified mailing on August 16, 2000. The Order included an opportunity for Mr. Eberlin to show cause why the order should not be entered.

31. Neither Mr. Eberlin nor the Respondent appeared on August 23, 2000, to show cause as to why the Cease and Desist Order should not be entered.

32. On May 30, 2001, the Board charged Mr. Eberlin with violating of H.O. §14-601 for practicing medicine without a license for reasons including, but not limited to, his provision of UBI treatments to patients.

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[15] CNA' s and other unlicensed persons are not authorized to take medical histories or to perform physical examinations for patients.

33. On August 12, 2001, Mr. Eberlin entered into a Consent Order with the Board in which he admitted that he practiced medicine without a license in connection with his interactions with patients at the IMC clinic.

34. The Respondent, through regular telephone, mail, facsimile and personal contact with Mr. Eberlin, referred at least twelve of his private practice patients to Mr. Eberlin for UBI treatment.

35. The Respondent had personal knowledge that Mr. Eberlin was not a physician and not competent to practice any delegated duties from a physician.

PATIENT SPECIFIC ALLEGATONS

Patient A

36. Patient A, a 47-year-old female, was self-referred to the Respondent on October 9, 1997. Patient A indicated, on a Patient History Sheet, that her chief complaints at the time were fatigue, fibromyalgia, headaches, and "sinuses". Patient A also indicated that her past medical history included: stomach problems, urinary tract infection, a thirty-five pound weight gain, hypoglycemia, insomnia, jaw surgery, breast biopsy, "tonsils", sinus surgery, depression, strep throat, back problems, arthritis, ear problems, chest pain and anxiety.

37. On October 15, 1997, the Respondent's assessment of Patient A included: CFS [chronic fatigue syndrome], fibromyalgia, migraine headaches, back pain and plantar fascitis. From October 17, 1997 through March 23, 2000, the Respondent treated Patient A for these and other medical conditions.

IMC Treatment

38. On May 12, 2000, Patient A completed an IMC Medical History Form (also the "history form"). The history form indicated that the Respondent referred Patient A to IMC.

39. On May 12, 2000 Patient A indicated on the history form that her medical history included allergies, frequent headaches, anxiety, sinus trouble, chest pain and past surgery.

40. Also on May 12, 2000, Patient A signed a consent form for photoluminescence[16]; the signature lines for the physician and nurse were left blank. The form reads as follows[17]:

Informed Consent for Photoluminescence

> I, [Patient A] wish to undergo Photoluminescence treatments and hereby grant authorization to Innovative Medical Clinics, Inc. to perform this treatment upon me [sic]
> I understand that these procedures will be formally explained to me. The treatment begins with a clinician inserting a needle into an arm vein (the gauge/size of the needle used will depend on the patency of the veins in my arm). Approximately 1.5 cc's of blood per pound of my body weight, but never more than 250 cc will be removed for irradiation. My blood will flow into a transfusion flask where it will be mixed with heparin[18], to prevent it from clotting; it will then pass through an irradiation chamber where it will be exposed to a controlled amount of ultraviolet energy. Once 250 cc of blood has been withdrawn the procedure is reversed and the blood is then returned to me, in a closed loop system, passing once more through the irradiation chamber and back into my vein. This procedure will take approximately one hour.
>
> I understand that there is a possibility of side effects, though infrequent and remote, that may be associated with these procedures. The side effects are usually, bleeding and/or bruising or a hematoma at the needle puncture site,

[16] The Respondent and others also refer to UBI as photoluminescence.
[17] The form is presented its entirety for Patient A. For the remaining patients it will be referred to as the Informed Consent for Photoluminescence.
[18] Heparin, a prescription medication, is an anticoagulant; an agent that thins blood.

low grade fever, clotting of the blood in the needle, cuvette and lines. There may be other side effects that I or the clinicians are unaware of.

I also understand that the efficacy of Photoluminescence has not been proven in controlled clinical tests as yet. I further understand that no one can guarantee me beneficial results in any manner; Furthermore, because this procedure is being offered to me under the condition that I release *Innovative Medical Clinics Inc.* from any legal responsibility for harm resulting from the use of this treatment my signature on this agreement will constitute a full and final release of legal responsibility resulting form the administration of Photoluminescence and/or and other medical treatment which may be necessary as a result thereof.
[Signed Patient A 5/12/00 – Physician and Nurse Signature lines are blank]

41. Patient A received six UBI treatments from May 12, 2000 through June 29, 2000 from Mr. Eberlin. Patient A was charged a total of $750.00 for the treatments.[19]

PATIENT B

42. Patient B, a 52-year-old female from Virginia Beach, Virginia, was referred to the Respondent by one of his other patients.

43. On July 18, 1995, Patient B completed the Patient History Sheet and indicated that her chief complaint was "severe chronic asthma". Patient B also indicated that her past medical history included: lung problems, stomach problems, [questionable] hiatal hernia, upper respiratory tract infections, weight gain, thyroid problems, high cholesterol, shortness of breath, past surgery (tonsillectomy, appendectomy, rectal fissure, and benign breast biopsy), depression, arthritis and sinus problems.

44. On July 18, 1995, the Respondent's note concerning his medical assessment of Patient B indicated that she had developed a chronic asthma/bronchitis condition, menopause, and depression. The Respondent also indicated Patient A had a thyroid problem since 1988 and a diagnosis of depression that was apparently due to side effects of Prednisone prescribed for the asthmatic/bronchitis condition.

[19] Not all the patient medical records contain billing information.

45. The Respondent's medical assessment of Patient B on that date included: chronic asthma and chronic obstructive pulmonary disease ("COPD"), FEV1 (measure of lung volume) last year was only 65%, hypothryoidism; postmenopausal, and suspected candidiasis (a fungal infection). The Respondent treated Patient B for these and other medical conditions from July 18, 1995 through June 4, 1996.

IMC Treatment

46. In April 1998, the Respondent referred Patient B to "IMC/Bill Eberlin" for UBI treatment.

47. On April 20, 1998, Patient B completed the IMC Medical History form. The history form indicated that the Respondent referred Patient B to IMC.

48. Patient B indicated on the IMC history form that she had multiple allergies, asthma, shortness of breath, chronic sinus trouble, swelling of neck muscles from Prednisone,[20] prolapsed bladder, wheezing and hypothyroidism.

49. Patient B signed the Informed Consent for Photoluminescence on April 20, 1998; the physician and nurse signature lines were left blank.

50. Patient B received two UBI treatments from Mr. Eberlin; on April 20, 1998 and June 1, 1998.

Patient C

51. Patient C, a 78-year-old female, was first seen by the Respondent on July 16, 1996. The Patient History Sheet indicated that Patient C's past medical history included "lung problems".

[20] Prednisone is a steroid; it is not clear from the history form or the medical records why Patient B was taking this medication.

52. On July 16, 1996, the Respondent's medical assessment of Patient C included: bronchiectasis, limitation of motion of the neck from a neck fracture, cold intolerance, rule out low thyroid, postmenopausal, and status post-hysterectomy since 1965. The Respondent treated Patient C for these and other medical conditions from July 16, 1996 through December 30, 1998.

IMC Treatment

53. On January 22, 1999, Patient C completed the IMC Medical History Form. The history form indicated that the Respondent referred Patient C to IMC.

54. Patient C indicated on the IMC history form that medical history included allergies, shortness of breath, sinus trouble, night urination and wheezing.

55. Patient C signed the Informed Consent for Photoluminescence on January 22, 1999; the doctor and nurse signature lines were left blank.

56. Patient C received 17 UBI treatments between January 22, 1999 and March 9, 2000 from Mr. Eberlin and Ms. K. G., another unlicensed individual.

57. Patient C's IMC/UBI treatment records include, in part, the following comments: January 22, 1999 treatment form indicates "heavy cough with thick yellowish, tenacious secretions...patient has difficulty breathing, very difficult vein to stick, cough heavily at times": July 1, 1999 "Rubber thing [sic] on NSS side was expulsed.[sic] Changed entire system, cuvette cleaned. Pt cannulated in the same spot right hand without problem"; March 9, 2000 Pt. fell at [illegible] hit head recommend she see Dr. for head exam."

58. There is no indication in the Respondent's medical records or the IMC records for Patient C that any physician was contacted for the symptomatology listed in paragraph 57 above.

Patient D

59. Patient D is a 30-year-old female who was first seen by the Respondent on January 27, 1999. The Patient History Sheet indicates that Patient D's chief complaints were: sore throat, sore neck, headaches, joint and muscular pain and a rash. Her past medical history included: stomach problems, urinary tract infection, upper respiratory tract infection, weight loss/gain, shortness of breath, sleeping problems, strep throat, fractures, headaches and past surgery.

60. On January 27, 1999, the Respondent's medical assessment of Patient D included: chronic rash; history compatible with Chronic Fatigue Syndrome; cold intolerance; rule out a low thyroid; history of constipation and suspected parasites. The Respondent treated Patient D for these and other medical conditions from January 27, 1999 through September 18, 2000.

61. On October 19, 1999, as documented in Patient D's medical record, the Respondent recommended "UBI four to six treatments for its antibacterial and yeast effect and to stimulate the immune system." The Respondent referred Patient D to IMC/William Eberlin for UBI treatments.

IMC Treatment

62. On November 6, 1999, Patient D completed the IMC Medical History Form. Patient D indicated that the Respondent referred her to IMC.

63. Patient D indicated in the IMC history form that her medical history included allergies, chest pain, and thyroid problems.

64. Also on November 6, 1999, Patient D completed the Informed Consent for Photoluminescence; the physician and nurse signature lines were left blank.

65. Patient D received approximately six UBI treatments from November 6, 1999 through February 12, 2000 from Mr. Eberlin.

66. During the February 5, 2000 UBI treatment, Patient D experienced a drop in blood pressure and dizziness. During the February 12, 2000 UBI treatment, Mr. Eberlin documented that Patient D felt faint when the "blood was being returned". The IMC notes do not indicate that a physician was contacted concerning the symptoms of hypotension and dizziness.

67. The Respondent's medical practice notes for Patient D indicate, on February 15, 2000, to "d/c UBI at this point." The Respondent's medical practice notes do not indicate, however, the patient's cardiovascular complications during the February 5, and 12, 2000 UBI treatments.

Patient E

68. Patient E, a 50-year-old female, was first seen by the Respondent on August 23, 1995. The Patient History sheet indicates that her chief complaint was a breast lump. Her past medical history included an upper respiratory tract infection.

According to the Respondent, Patient E was aware of the probable diagnosis of breast cancer and wanted an opinion from a physician specializing in "alternative" therapies.

69. Patient E was treated by the Respondent from August 1995 through July 24, 2002 for alternative nutritional and other non-conventional therapies for breast cancer and other medical conditions.

70. The Respondent noted in Patient E's medical practice record on October 22, 1999, to "consider UBI to help stimulate the immune system". On January 18, 2002, the Respondent noted in Patient E's medical record, "She is getting some UBI treatments which has also been giving her a little more energy."

IMC Treatment

71. On November 3, 1999, Patient E completed the IMC Medical History Form. Patient E indicated that the Respondent referred her to IMC and documented her medical history consisted of breast cancer.

72. On November 3, 1999, Patient E completed the IMC Informed Consent for Photoluminescence; the physician and nurse signature lines were left blank.

73. From November 3, 1999 through March 22, 2000, Patient E received approximately six UBI treatments from Mr. Eberlin.

Patient F

74. Patient F, a 73-year-old male, was first seen by the Respondent on July 29, 1999. Patient F's History Sheet indicates that his past medical history included: weight loss/gain, diabetes, history of drug/alcohol abuse, hypertension, chronic diarrhea, arthritis, recurrent muscle spasm, numbness in his right index toe area and a hip replacement.

75. On July 29, 1999, the Respondent's medical practice notes concerning Patient F indicate that he is interested in UBI treatments. The Respondent's medical practice notes for Patient F on July 29, 1999, do not contain a medical assessment, or any other indication for the treatment.

76. Patient F returned to the Respondent's medical practice on September 15, 1999. At that time, the Respondent included in his medical assessment of Patient F: mild peripheral neuropathy, rule out radiculopathy of the right leg, macrocytic anemia, chronic diarrhea and low back pain. The Respondent treated Patient F for these and other medical conditions from September 15, 1999 through October 9, 2002.

IMC Treatment

77. Patient F completed the IMC Medical History form on October 4, 1999. Patient F indicated that the Respondent referred him to IMC.

78. On October 4, 1999, Patient F's medical history included: high blood pressure, swelling of the ankles, trouble with urination and diabetes.

79. Also on October 4, 1999, Patient F completed the IMC Informed Consent for Photoluminescence form; the physician and nurse signature lines were left blank.

80. From October 4, 1999 through November 8, 1999, Patient F received four UBI treatments from Mr. Eberlin.[21]

81. Patient F was charged a total of $570.00 for the four UBI treatments. Patient F's IMC record includes a letter from a third party insurer requesting additional

[21] Patient F returned again to the Respondent's medical practice on October 6, 1999 complaining of, among other things, persistent diarrhea. With regard to the complaint, the Respondent recommended trying UBI treatments. Patient F already had a UBI treatment on October 4, 1999.

information concerning the "surgical services"[22] provided to Patient F from October 4, 1999 through November 8, 1999.

Patient G

82. Patient G, a 42-year-old female, was first seen by the Respondent on March 6, 1996. Patient G's Patient History Sheet indicates that her chief complaints were fatigue and weight gain. Her past medical history included: kidney problems, stomach problems, upper respiratory infection, weight loss/gain, sleeping problems, depression, strep throat, back problems, headaches, sinus problems, chest pains, anxiety and past nasal surgery.

83. On that date, the Respondent's medical assessment of Patient G included: low back pain, anxiety-depression, history of allergic rhinitis, rule out low adrenal [sic], cold intolerance, weight gain and rule out low thyroid levels. The Respondent treated Patient G for these and other medical conditions from March 6, 1998 through August 25, 2000.

84. On December 8, 1998, the Respondent's medical assessment of Patient G included: fibromyalgia, back pain, insomnia, CFS, and suspected mixed connective tissue disease. At that time, the Respondent's proposed treatment, among other things, was to consider UBI.

85. On January 12, 1999, the Respondent's medical assessment of Patient G included: joint pain, muscle pain, insomnia and chronic fatigue symptoms. The Respondent's proposed treatment, among other things, was to recommend UBI.

[22] Apparently this communication is in reference to a claim submission for UBI.