CURRICULUM VITAE
LAST UPDATED JANUARY 1, 2012
JAMES ARTHUR NEUBRANDER, M.D., F.A.A.E.M.

Personal Data: Date of Birth: October 29, 1949.
Place of Birth: Ashland, Ohio.
Citizenship: United States of America.
Marital Status: Divorced; father of two adult children.
Religious Background: Protestant.
Residence: 7320 Falston Circle, Old Bridge, NJ, 08857.
Telephone: Private number.

Consultation & Administrative Offices: 485A Route 1 South
Suite 320
Iselin, New Jersey 08830
Telephone (732) 726-1222
Fax (732) 726-1228
Email: staff@drneubrander.com; rick@drneubrander.com
Website: www.drneubrander.com

Education:

August 1972 to October 1975	Loma Linda University, Loma Linda, California, Doctorate of Medicine Degree.
September 1968 to June 1972	Southern College, Collegedale, Tennessee, Bachelor of Science Degree.
June 1971 to June 1972	Memorial Hospital, Chattanooga, Tennessee, in Association with Southern College, Collegedale, Tennessee, Medical Technologist Degree.

Internship and Residency Programs:

January 1977 to January 1980	University of South Florida Affiliated Hospitals, Tampa, Florida: James A. Haley Veterans Administration Hospital, Women's Hospital, Tampa General Hospital. Residency: Anatomical, Surgical, and Clinical Pathology.
January 1976 to January 1977	University of South Florida Affiliated Hospitals, Tampa, Florida: James A. Haley Veterans Administration Hospital, Women's Hospital, Tampa General Hospital. Internship: Anatomical, Surgical, and Clinical Pathology.

Medical Training:

September 2011	QEEG-Guided Evaluation and Treatment of ADD, Asperger's, & Autism, 19th Annual Conference, International Society for Neurofeedback and Research,

	Carefree, AZ.
September 2011	QEEG and Neurofeedback Application in Sport Psychology, 19th Annual Conference, International Society for Neurofeedback and Research, Carefree, AZ.
September-October, 2010	Basics of EEG for the Neurofeedback Practitioner; Effective Intervention with Asperger's Syndrome, 18th Annual Conference, International Society for Neurofeedback and Research, Boulder, CO.
September, 2009	Metacognition Strategies for Children and Adults; Coherence Assessment Training;; QEEG Subtype for ADD and Autistic Spectrum Disorders 17th Annual Conference, International Society for Neurofeedback and Research, Indianapolis, IN.
November 2008	Intensive Course in Transcranial Magnetic Stimulation, Harvard Medical School, Boston, MA.
October 2008	Hyperbaric Oxygen Therapy Physician Training Course, International College of Integrative Medicine with IHA, Pittsburg, PA.
August 2008	QEEG and LORETA Analysis for Determination of Neurofeedback Protocols; Connectivity Guided Neurofeedback for Autistic Spectrum Disorders; Neurofeedback for Childhood Disorders; 16th Annual Conference, International Society for Neurofeedback and Research, San Antonio, TX.
March 2008	Hyperbaric Oxygen Physician Training Course, International College of Integrative Medicine, Nashville, TN.
November 2007	Neuropsychologist Training Course, Instructors: Philip A. De Fina and Stu Cutler, Ph.D. Staten Island, NY.
June 2007	Hyperbaric Medicine Team Training, International ATMO at Nix Medical Center, San Antonio, TX.
January 2007	Basic Cardiac Life Support, UMDNJ Medical Center, Newark, New Jersey.
November 2006	Hyperbaric Oxygen Therapy Workshop, ACAM and IHA Joint Training for Professionals, Palm Springs, CA.
June 2006	Hyperbaric Oxygen Technical Training, Wisconsin Integrative Hyperbaric Center,

	Fitchburg, WI.
May 2006	Hyperbaric Oxygenation Usage, Protocol & Safety, ACAM and IHA Joint Training Session, Dallas, TX.
July 2003	Mini DAN! Physician Training Course, Sponsored by the Autism Research Institute, Los Angeles, CA.
October 2002	DAN! Conference Physician Practicum, Autism Research Institute Semi-Annual Symposium, San Diego, CA.
May 2002	DAN! Conference Physician Practicum, Autism Research Institute Semi-Annual Symposium, Boston, MA.
April 2002	Clinical Nutrition for the Practicing Physician, American Academy of Environmental Medicine, St. Louis, MO.
January 2002	Open Windows Essential Training, International Child Development Research Center, Orlando, FL.
October 2001	DAN! Conference Physician Practicum, Autism Research Institute Semi-Annual Symposium, San Diego, CA.
May 2001	DAN! Conference Physician Practicum, Autism Research Institute Semi-Annual Symposium, Atlanta, GA.
December 2000	American Academy of Anti-Aging Medicine Physician Practicum, A^4M Eighth International Congress on Anti-Aging & Biomedical Technologies, Las Vegas, NV.
September 2000	DAN! Conference Physician Practicum, Autism Research Institute 6^{th} Annual Symposium, San Diego, CA.
October 1999	The American EPD Society, Sixth Annual Scientific Conference, Coeur d'Alene, ID.
March 1999	International EPD Training Course Including the Latest Advancements and Techniques Being Utilized Worldwide, International EPD Society Annual Symposium, Streatley, England.
April 1998	Biological Manipulation of Biomembranes, The American Academy of Environmental Medicine, Potomac, Maryland.

April 1998	Environmental Medicine in Everyday Practice: Comprehensive, Cause-Oriented, Preventive Care, Review of Core Curriculum Instructional Course, American Academy of Environmental Medicine, Potomac, Maryland.
April 1998	The American EPD Society, Fifth Annual Scientific Conference, Potomac, Maryland.
July 1997	The American EPD Society, Fourth Annual Scientific Conference, Colorado Springs, Colorado.
April 1997	Nutritional Medicine for Current Practice, Core Curriculum Instructional Course, Part IV, American Academy of Environmental Medicine, Kansas City, Missouri.
September 1996	The American EPD Society Third Annual Scientific Conference, Milwaukee, Wisconsin.
May 1996	Free Radical Pathology in Relation to Vascular Disease, American College for Advancement in Medicine, Orlando, Florida.
April 1996	Indoor Air Quality Assessment and Remediation, Environmental Protection Agency with the American Academy of Environmental Medicine, Dearborn, Michigan.
November 1995	Chelation Therapy, American College for Advancement in Medicine, Colorado Springs, Colorado.
October 1995	The American EPD Society, Second Annual Scientific Conference, Tucson, Arizona.
September 1995	Diagnosis and Treatment of Heavy Metal Toxicity, Great Lakes College of Clinical Medicine, Grand Rapids, Michigan.
August 1995	EPD and IV Nutrient Therapies, Directed by W.A. Shrader, Jr., M.D., and staff, Santa Fe, New Mexico.
May 1995	Nutritional Medicine for Current Practice, Core Curriculum, Part IV, American Academy of Environmental Medicine, Houston, Texas.
May 1995	Chemical Exposure, Toxicity, and Sensitivity; Core Curriculum, Part III,

	American Academy of Environmental Medicine, Houston, Texas.
March 1995	Diagnostic Testing and Immunotherapy, Basic Curriculum, Pan American Allergy Society, San Antonio, Texas.
January 1995	Prevention of Cruelty to Children, Certificate of Completion, The New York State Education Department, Cultural Education Center, Albany, New York.
October 1994	The American EPD Society, First Annual Scientific Conference, Virginia Beach, Virginia.
September 1994	Advanced Cardiac Life Support: Saint Francis Medical Center, Trenton, New Jersey.
August 1994	Basic Cardiac Life Support: Somerset Medical Center, Somerville, New Jersey.
May 1994	Diagnostic Testing and Immunotherapy in Environmental Medicine, Core Curriculum, Part II, American Academy of Environmental Medicine, Kansas City, Missouri.
April 1994	Environmental Medicine in Everyday Practice, Core Curriculum, Part I, American Academy of Environmental Medicine, Kansas City, Missouri.
January/February 1994	Advanced Training in Environmental Treatment Modalities, Under the Supervision and Direction of William Rea, M.D., Environmental Health Center, Dallas, Texas.
January 1994	Violent and Behaviorally Disturbed Children, Diagnosis and Treatment, William Walsh, Ph.D., Carl C. Pfeiffer Treatment Center, Naperville, Illinois.
November 1993	Advanced Training in Environmental Diagnosis and Treatment of Children: Emphasis on Indoor Air Quality, Specifically as Related to the School Environment, Doris Rapp, M.D., Environmental Allergy Center, Buffalo, New York.

Board Certification & Fellowship:

October 1995	Diplomate – International Board of Environmental Medicine.
October 1995	Fellow – American Academy of Environmental Medicine.
November 1995	Diplomate Candidate – American College for Advancement in Medicine.

Licensure:

September 1988 to present	The State Board of Medical Examiners of New Jersey, License #MA052272, NPI #1275753063.
February 1995 to January 2003	Commonwealth of Pennsylvania Board of Medical Licensure, License #MD-055212-L.
February 1995 to January 2003	The University of the State of New York, State Education Department, License #198687.
July 2001 to January 2003	Composite State Board of Medical Examiners of Georgia, License #050326.
January 1977 to January 1991	The State Board of Medical Examiners of Florida, License #29277.
July 1989 to July 1991	State of Illinois, Department of Professional Regulation, License #036-079411.
January 1977	National Board of Medical Examiners of the United States of America, Certificate #169857.

Present Position:

September 1997 to present	Medical Director, Private Practice – Autism Spectrum Disorders, Methylation/Transsulfuration/Folate Disorders, Hyperbaric Oxygen Therapy, PANDAS, IVIG Therapy, QEEG-Directed Neurofeedback, Detoxification Techniques Including Heavy Metal Detoxification, Environmental Medicine, Preventive Medicine Including Prenatal Consultations, Allergy and LDA Therapy, Nutritional Medicine, Metabolic and Molecular Medicine: Iselin, New Jersey.
January 2008 to present Limited appointment for specific projects	Adjunct Assistant Professor, Department of Pharmaceutical Sciences, Northeastern University, Boston, MA.

Previous Positions and Work Experiences:

June 2009 to June 2011	Medical Director of Autism Research, International Brain Research Foundation, Edison, NJ.
February 2008 to June 2011	Medical Director of Comprehensive Neuroscience Center, Edison, NJ.
July 1995 to August 1997	Private Practice -- Autism Spectrum Disorders, Environmental Medicine, Preventive Medicine, Allergy, Nutritional Medicine, Metabolic and Molecular Medicine: Princeton, Hopewell, and Millburn, New Jersey.
April 1995 to July 1995	Environmental Allergy Center: Buffalo, New York.
April 1988 to April 1995	Carl C. Pfeiffer Institute, Skillman, New Jersey, Responsibilities: • Acting Director of the Institute, November 1988 to October 1989. • Director of the Laboratory, 1988-1989; 1992-1995.

- Education and Training of Nurses and Staff Physicians; Topics Included Basic and Advanced Environmental Medicine, Nutrition, Laboratory Principles and Interpretation.

January 1988 to June 1989 — Director, Nutrition Medical Center: Tampa, Florida.

January 1980 to April 1988 — Private Practice, Environmental and Preventive Medicine: Tampa, Florida. Medical Insurance Examiner: Tampa, Florida.

Board Membership:

Board of Directors, American EPD Society, Santa Fe, New Mexico, January, 1998 to October 2000.

Board of Directors Elect, American Academy of Environmental Medicine, Wichita, Kansas October, 1996.

Board of Directors, Schizophrenia Foundation of New Jersey, Skillman, New Jersey, December 1988 to November 1994.

- Secretary 1989 to 1994.

Committee Memberships and Scientific Advisory Council Appointments:

International Brain Research Foundation, Secaucus, NJ.

The American Medical Autism Board, Seven Hills, OH.

DAN! Europe's Scientific and Medical Advisory Board. Bologna, Italy.

International Hyperbaric Association, Madison, WI.

- Executive Committee Member for HBOT and Autism.
- Co-appointee to create HBOT Physician Consensus Statement.
- Physician Advisory Member.

US Autism & Asperger Association, Park City, Utah.

UDAAN for the Disabled and Autism Project, New Dehli, India.

Co-Chairman, Scientific Committee, American EPD Society, Santa Fe, New Mexico.

Violent and Behaviorally Disturbed Children: Pilot Research Project Design, Princeton BioCenter, Skillman, New Jersey.

Scientific and Finance Committees: Princeton BioCenter, Skillman, New Jersey.

Special Meetings, Committees, or Affiliations:

January 21 to 23, 2011 — Defeat Autism Now Think Tank, Autism Research Institute, Dallas, TX.

March, April 2010 — Autism Y-Axis Rating Scale Project Design, International Brain Research Foundation, Edison, NJ.

August 8 & 9, 2009 — Defeat Autism Now Think Tank, Autism Research Institute,

	Chicago, IL.
July 11, 2009	Physician Round Table, US Autism & Asperger Association, Los Angeles, CA.
January 17 & 18, 2009	Defeat Autism Now Think Tank, Autism Research Institute, Dallas, TX.
October 24, 2008	Defeat Autism Now Think Tank, Autism Research Institute, San Diego, CA.
April 2 & 3, 2008	Defeat Autism Now Think Tank, Autism Research Institute, Cherry Hill, NJ.
October 10 & 11, 2007	Defeat Autism Now Think Tank, Autism Research Institute, Anaheim, CA.
April 18 & 19, 2007	DAN! Think Tank, Autism Research Institute, Alexandria, VA.
May 4, 2006	International Hyperbaric Association Planning Committee Design, Dallas, TX.
April 5 & 6, 2006	DAN! Think Tank, Autism Research Institute, Washington, DC.
October 26 & 27, 2005	DAN! Think Tank, Moderator for Methylation Discussion, Autism Research Institute, Long Beach, CA.
April 14, 2005	DAN! Think Tank, Autism Research Institute, Long Beach, CA.
September 29 & 30, 2004	DAN! Think Tank and 2nd Mercury Consensus Meeting, Autism Research Institute, Los Angeles, CA.
July 22 & 23, 2004	M.I.N.D. Institute Research Trial Focus Group, Sacramento, CA.
April 15, 2004	DAN! Think Tank, Autism Research Institute, Washington, DC.
January 22 to 25, 2004	DAN! Think Tank,

	Autism Research Institute, New Orleans, LA.
October 2, 2003	DAN! Think Tank, Autism Research Institute, Portland, OR.
May 15, 2003	DAN! Think Tank, Autism Research Institute, Philadelphia, PA.
October 24, 2002	DAN! Think Tank, Autism Research Institute, San Diego, CA.
July 12 to 14, 2002	DAN! Think Tank, Autism Research Institute, San Diego, CA.
May 9, 2002	DAN! Think Tank, Autism Research Institute, Boston, MA.
October 4, 2001	DAN! Think Tank, Autism Research Institute, San Diego, CA.
May 10, 2001	DAN! Think Tank, Autism Research Institute, Atlanta, GA.
February 9 to 11, 2001	DAN! Mercury Consensus Meeting, Autism Research Institute, Dallas, TX.
September 14, 2000	DAN! Think Tank, Autism Research Institute, San Diego, CA.

Physician Training: Instructor

October 30, 2011	Co-Instructor for Board Certification of Physicians Who Incorporate Biomedical Treatments for Autism Spectrum Disorders into Their Practices, American Medical Autism Board, Seattle, WA.
July 24, 2011	Co-Instructor for Board Certification of Physicians Who Incorporate Biomedical Treatments for Autism Spectrum Disorders into Their Practices, American Medical Autism Board, Independence, OH.
May 3 through May 11, 2010	Chief Medical Advisor for Fifty Patients from Australia and the Surrounding Regions; Acted as a Mentor for the Treating Physician during Co-consultation with the Physician's Patient and Patient's Family while

	Simultaneously Facilitating a Discussion of the Patient's Case in a Round Table Forum with Other Physicians and Clinicians Who Were Also in Attendance, Walsh Research Institute Physician Training Course, Sponsored by Bio Balance, Sydney, Australia.
March 28, 2010	Co-Instructor for Board Certification of Physicians Who Incorporate Biomedical Treatments for Autism Spectrum Disorders into Their Practices, American Medical Autism Board, Troy, MI
July 12, 2009	Co-Instructor for Board Certification of Physicians Who Incorporate Biomedical Treatments for Autism Spectrum Disorders into Their Practices, American Medical Autism Board, Los Angeles, CA.
April 27 through May 5, 2009	Chief Medical Advisor for Fifty-six Patients from Australia and the Surrounding Regions; Acted as a Mentor for the Treating Physician during Co-consultation with the Physician's Patient and Patient's Family while Simultaneously Facilitating a Discussion of the Patient's Case in a Round Table Forum with Other Physicians and Clinicians Who Were Also in Attendance, Walsh Research Institute Physician Training Course, Sponsored by Bio Balance, Sydney, Australia.
April 29, 2009	Physician Seminar: Strategies for the Most Effective Treatment Outcomes when Treating Children on the Autism Spectrum Including Universal Principles Necessary for Recovery, Walsh Research Institute Physician Training Course, Sponsored by Bio Balance, Sydney, Australia.
February 22, 2009	Co-Instructor for Board Certification of Physicians Who Incorporate Biomedical Treatments for Autism Spectrum Disorders into Their Practices, American Medical Autism Board, Novi, MI.

<u>Presentations</u>:

November 16, 2011	Australia and America: The Ocean between Us Just Became a Tiny Little Pond, Autism Exit Australia, Hobart, Tasmania, Australia.
November 14, 2011	Australia and America: The Ocean between Us Just Became a Tiny Little Pond, Autism Exit Australia, Melbourne, Victoria, Australia.
October 30, 2011	Interactions between the Environment and Human Health, U.S. Autism & Asperger Association World Conference,

	Seattle, WA.
October 30, 2011	Cerebral Folate Deficiency and its Association with Methylation, Transsulfuration, and Glutathione, American Medical Autism Board, Seattle, WA.
October 30, 2011	Mitochondrial Dysfunction in Autism, American Medical Autism Board, Seattle, WA.
July 24, 2011	Cerebral Folate Deficiency and Autism, American Medical Autism Board, Independence, OH.
July 24, 2011	Mitochondrial Dysfunction in Autism, American Medical Autism Board, Independence, OH.
July 23, 2011	Discovering New Treasures behind Old Doors, The American Medical Autism Board's Third International Conference on Autism Spectrum Disorders, Independence, OH.
May 29, 2011	Hyperbaric Oxygen Therapy Update and Various HBOT Protocols Used for Autism Spectrum Disorders, Autism One Conference: Autism Recovery on a Budget: Empowering Parents, Lombard, IL.
April 2, 2011	Presentation 2 of 2; Evidence-based Pharmaceutical Intervention in Autism and an Overview of Advanced Neurodiagnostic and Neuroimaging Procedures that Precede the New Noninvasive Neuromodulatory Treatment Protocols for Children on the Autism Spectrum, Symposium on Autism: An Interdisciplinary Approach, Institute for Continuing Education with the New York City Health and Hospitals Corporation, New York City, NY.
April 2, 2011	Presentation 1 of 2; Autism Treatment Overview, Symposium on Autism: An Interdisciplinary Approach, Institute for Continuing Education with the New York City Health and Hospitals Corporation, New York City, NY.
February 28, 2011	TACA Parent Mentoring Program AM Duel Teleconferences, East Coast and West Coast Chapters, HBOT Training Course, Edison and Old Bridge, NJ.
January 8, 2011	Exploring Multiple Modalities to Treat Autism Spectrum Disorders, TACA, NJ Chapter, Edison, NJ.
September 11, 2010	Autism: A Treatable Disorder With Recovery A Definite Possibility, 2010 Fall Conference of the Pennsylvania Association of Naturopathic Physicians,

	Pittsburgh, PA.
May 30, 2010	Pre and Post QEEG Studies Documenting the Effectiveness of Four Primary Treatments Used in Our Clinic: Injectable Methylcobalamin, Hyperbaric Oxygen Therapy, Chelation, and QEEG-directed Neurofeedback, Autism One Conference: Redefining Autism, Chicago, IL.
May 16, 2010	Visualization by qEEG Brain Maps to Document the Correlation between Clinical Benefits and Positive Electrical Changes from the Use of Methylcobalamin Injections and HBOT for Autism Spectrum Disorders, World Autism Conference Asia 2010, Hong Kong Academy of Medicine, Hong Kong.
May 8, 2010	The Autism Clock Can Be Reset: The Power of Biomedical Treatments to Accomplish this Goal Including, but not Limited to Methylcobalamin Injections and Hyperbaric Oxygen Therapy, Walsh Research Institute Sydney Outreach Conference, Sponsored by Bio Balance, Sydney, New South Wales, Australia.
March 27, 2010	Autism Spectrum Disorder's Phase Reset Abnormality Resulting in Decreased Neuronal Recruitment and Increased Neuronal Processing Times. Preliminary Evidence Indicates that both HBOT and Methyl-B_{12} begin to Correct this Phase Shift: Phase Lock Disconnect, The American Medical Autism Board's Second International Conference on Autism Spectrum Disorders, Troy, MI.
March 20, 2010	Autism Update: Four Primary Treatments Used In Our Clinic -- Injectable Methylcobalamin, Hyperbaric Oxygen Therapy, Mercury And Heavy Metal Detoxification, Plus QEEG-directed Neurofeedback, International Academy of Oral Medicine and Toxicology, Galloway, NJ.
January 30, 2010	The Scientific Stepping Stones Used to Cross the Treacherous Streams of Autism, BAN Sweden Autism Conference, Stockholm, Sweden.
October 17, 2009	Introduction of Hyperbaric Oxygen Therapy Including its Use for Stroke Victims, Institute for Continuing Education with the New York City Health and Hospitals Corporation, New York City, NY.
August 8, 2009	QEEG Documentation of HBOT Effectiveness for Autism Spectrum Disorders, Think Tank Presentation for the Autism Research Institute and Defeat Autism Now, Chicago, IL.

July 12, 2009	Quantitative EEG Evidence Supporting Key Biomedical Treatments for Autism Spectrum Disorders Plus An Overview Of The Cost To Benefit Ratio for the Primary Biomedical Treatments Currently Being Used, U.S. Autism & Asperger Association Conference, Los Angeles, CA.
May 2, 2009	An Update for Parents: The Most Effective Biomedical Treatments Being Used for Children on the Autism Spectrum, Walsh Research Institute Sydney Outreach Conference, Sponsored by Bio Balance, Sydney, New South Wales, Australia.
February 21, 2009	State of the Art Use of Methylcobalamin and Hyperbaric Oxygen Therapy for Children on the Autism Spectrum, The American Medical Autism Board's First International Conference on Autism Spectrum Disorders, Novi, MI.
November 19, 2008	Dual Presentation, Part II: Philip A. De Fina, Ph.D., and James A. Neubrander, M.D., Successfully Treating Children with Autism by Combining Biometric, Neurometric, Psychometric, and Educational Modalities -- Taking the Next Steps, The Staten Island NY City School System with the International Brain Research Foundation, Staten Island, NY.
October 18, 2008	Treatments Commonly Used for Children with Autism, Autismo y Trastornos de la Atencion, III Congresso Internacional, Ponce, Puerto Rico.
September 5, 2008	Hyperbaric Oxygen Therapy for Children on the Autism Spectrum, Panel Discussion for Parents and Practitioners, Sponsored by the International Hyperbaric Association at the U.S. Autism & Asperger Association Semi-annual Conference, Austin, TX.
September 5, 2008	A Review of the Cost to Benefit Ratio of the Most Popular Treatments Used for Children on the Autism Spectrum, US Autism & Asperger Association Semi-annual Conference, Austin, TX.
June 20, 2008	What's Hot! What's Not! 1st Annual Conference, NAA Illinois Chapter, Pittsburg, KS.
May 25, 2008	Gambling Will Cost You a Lot of Money and Belongs to be Done in Las Vegas, Not in Your Home. Know What Treatments Work and How to Get Them to Work Even Better, Autism One Conference, Chicago, IL.

April 5, 2008

"So, How Do I Get the Stuff in There?" – Taking the Biomedical Approach Home; Multiple Demonstrations followed by a Parent Practicum Involving Task Completion Exercises:

- Organization and Approaches to Administering Supplements (Mika Bradford);
- Use of Oral Syringes (Denise Fulton);
- Techniques Used to Successfully Teach Pill Swallowing (Doreen Granpeesheh, Ph.D.);
- The Correct Technique for Subcutaneous Methyl-B_{12} Injections (James Neubrander, M.D.);

Defeat Autism Now 2008 Spring Conference,
Cherry Hill, NJ.

March 27, 2008

Dual Presentation: Philip A. De Fina, Ph.D., and James A. Neubrander, M.D.,
Successfully Treating Children with Autism by Combining Biometric, Neurometric, Psychometric, and Educational Modalities,
The NY City School System, City Access, and the International Brain Research Foundation,
Staten Island, NY.

March 13, 2008

Rationale for the Use of Hyperbaric Oxygen Therapy in Children Suffering from Autism,
Hyperbaric Oxygen Physician Workshop,
International College of Integrative Medicine with the International Hyperbaric Oxygen Association,
Nashville, TN.

February 23, 2008

The Experts Are Not Always Right because Bumblebees *Can Fly* and Children with Autism *Can Recover*!
Autism Society of Illinois with the Illinois Chapter of NAA,
Chicago, IL.

February 16, 2008

Don't Gamble! Learn How to Save Money and Win More Often as You Choose Treatment Options for Your Child,
US Autism & Asperger Association with Autism Today Biennial Conference,
Orlando, FL.

November 10, 2007

It's Time to Talk about Which Treatments Use Your Time and Spend Your Money Most Wisely!
National Autism Association Conference,
Atlanta, GA.

November 9, 2007

Hyperbaric Oxygen Therapy for Children on the Autism Spectrum, Panel Discussion for Parents and Practitioners,
Sponsored by the International Hyperbarics Association at the National Autism Association Conference,
Atlanta, GA.

October 27, 2007

Oxygeno Hiperbarica en el Transtorno Generalides del Desarrollo,
Asociacion Latinoamerica de Medicina Hiperbarica y Instituto Politecnico Nacional y Tercer Congreso Intenacionale de Medicina del Deporte Rehabilitacion y Cuarto Congreso de Medicina Hiperbarica,
Santorio Espanol,
Mexico City, Mexico.

October 13, 2007	Parents and Physicians as Partners, (lecture given with Stan Kurtz, parent activist and father of a recovered child), Defeat Autism Now 2007 Fall Conference, Anaheim, CA.
October 12, 2007	Hyperbaric Oxygen Therapy for Children on the Autistic Spectrum, Panel Discussion for Parents and Practitioners, Sponsored by the International Hyperbarics Association at the Defeat Autism Now Fall Conference, Anaheim, CA.
October 10, 2007	Comparison of Clinical Responsiveness to Various Hyperbaric Oxygen Therapy Protocols, Defeat Autism Now Think Tank, Anaheim, CA.
September 16, 2007	Dispelling the Myth that Autism is Always Permanent: Multiple Approaches to Treating Autism, a Multimodality Disorder , 1st UDAAN Neural Repair and Neuro-rehabilitation Conference, Indian Institute of Technology, Hauz Khas, New Dehli,, India.
September 2, 2007	The Practical Use of Hyperbaric Oxygen Therapy in the Treatment of Autism, 2007 Asian Autism Conference, The Hong Kong Academy of Medicine, Aberdeen, Hong Kong.
September 1, 2007	The Methyl Form of Vitamin B_{12} Used for the Treatment of Autism – Insight and Update, 2007 Asian Autism Conference, The Hong Kong Academy of Medicine, Aberdeen, Hong Kong.
August 10, 2007	Hyperbaric Oxygen Therapy Panel Discussion, Sponsored by The International Hyperbarics Association, US Autism & Asperger Association Semi-annual Conference, Denver, CO.
August 10, 2007	Hyperbaric Oxygen Therapy for Children with Autistic Spectrum Disorders: Clinical Responses from 20,000 Treatment Hours, US Autism & Asperger Association Semi-annual Conference, Denver, CO.
August 9, 2007	Methyl-B_{12}: Doing It Right! Methylcobalamin Update, US Autism & Asperger Association Semi-annual Conference, Denver, CO.
May 27, 2007	Clinical Responses of Over 15,000 Hours of Hyperbaric Oxygen Therapy for Children on the Autistic Spectrum, Autism One Conference, Chicago, IL.
May 27, 2007	Lights, Cameras, Action – Methyl-B_{12} Returns to the Spotlight for Treating Children on the Autistic Spectrum ,

	Autism One Conference, Chicago, IL.
May 20, 2007	Autism Treatment: Now and Tomorrow**,** Pontificia Universita' San Tommaso D'aquino, DAN! Europe, Rome, Italy.
April 20, 2007	HBOT Panel Discussion for Parents and Physicians, Sponsored by The International Hyperbarics Association at the DAN! Spring Conference, Alexandria, VA.
March 10, 2007	Clinical Responses Using Hyperbaric Oxygen Therapy for Children on the Autistic Spectrum, Bridging the Gap and Natural Approaches for Autism Treatment, Quad City Autism Coalition, Moline, IL.
March 10, 2007	The Birth, Death, and Resurrection of Methyl-B_{12}, Bridging the Gap and Natural Approaches for Autism Treatment, Quad City Autism Coalition, Moline, IL.
March 5, 2007	Hyperbaric Air, Mild Hyperbaric Oxygen, and Conventional Hyperbaric Oxygen Therapy to Treat Children on the Autistic Spectrum and the Synergistic Effect Created by Methylcobalamin, Department of Medicine, Tokushima University, Tokushima, Japan.
March 2, 2007	Clinical Observations Using Hyperbaric Air and Mild Hyperbaric Oxygen Therapy for More than 15,000 Hours with Children on the Autistic Spectrum and the Synergistic Effect Created by Methylcobalamin Pre-loading and Concurrent Therapy, IHA-Japan Conference, Tokyo, Japan.
January 19, 2007	Methylcobalamin (methyl-B_{12}) Treatment, Biomedical Approaches to Autistic Spectrum and Neurodevelopmental Disorders Conference, Co-sponsored by the Department of Cell Biology and Anatomy and the Faculty of Medicine, University of Calgary, Calgary, AB, Canada.
December 10, 2006	Methylcobalamin Speaks Fluent French, Autism for 2007: Encouraging Advances, Ariane Autism Association, Paris, France.
November 1, 2006	Clinical Observations Using Mild Hyperbaric Oxygen Therapy for More than 7500 Hours with Children on the Autistic Spectrum, Hyperbaric Oxygen Therapy Workshop, ACAM and IHA Joint Training for Professionals, Palm Springs, CA.

August 13, 2006	Methylcobalamin: National is *Good*. International is *Better*. Once the Martians Find Out, Universal May Become the *Best*! 2006 Asian Autism Conference, The Hong Kong Academy of Medicine, Aberdeen, Hong Kong.
August 10, 2006	Methylcobalamin's Rise from Pauper to Prince: An Update on Methylcobalamin's Evolutionary Journey for Autistic Spectrum Disorders, US Autism & Asperger Association Conference, Park City, UT.
August 9, 2006	Hyperbaric Oxygen: Practical Use for the Practicing Physician, Co-presenter with Dan Rossignol, M.D. Hyperbaric Oxygen Therapy Physician Training Course, Sponsored by The International Hyperbarics Association at the US Autism & Asperger Association Conference, Park City, UT.
May 28, 2006	Methylcobalamin's Evolutionary Journey for Autistic Spectrum Disorders Autism One Conference, Chicago, IL.
April 8, 2006	The Methylation Puzzle: Methyl-B_{12} et. al. Methylation Panel Presentation with Derrick Lonsdale, M.D, Richard Deth, Ph.D., Jill James, Ph.D., DAN! Spring Conference, Washington, D.C.
April 8, 2006	Physicians HBOT Round-Table Panel Member for Physicians Sponsored by The International Hyperbaric Association at the DAN! Spring Conference, Washington, D.C.
April 7, 2006	Physicians HBOT Round-Table Panel Member for Parents Sponsored by the International Hyperbarics Association at the DAN! Spring Conference, Washington, D.C.
November 13, 2005	Methyl-B12: The Good, the Bad, the Ugly -- and the Beautiful Too! National Autism Association, Myrtle Beach, SC.
October 27, 2005	Making Methyl-B_{12} Work Optimally for Children on the Spectrum, DAN! Fall Conference, Long Beach, CA.
October 15, 2005	Methyl-B_{12}: Safe, Simple, Scientific, Swift, and Sure, Action Against Autism Conference, Royal College of Physicians, Edinburgh, Scotland, UK.
October 14, 2005	Methylation and Transsulfuration Practicum for Practitioners, Action Against Autism Conference, Royal College of Physicians, Edinburgh, Scotland, UK.

May 29, 2005	Methyl-B12: A Powerful Biomedical Treatment that is Natural, Predictable, and Reproducible, Autism One Conference, Chicago, IL.
May 10, 2005	Major and Minor Biomedical Treatment Options that Often Help Children on the Spectrum, Center for Developmental Excellence, Cherry Hill, NJ.
April 19, 2005	A Skeptic's Challenge to Biomedical Treatments: "You Say It Works but Can You Prove It?" North Jersey Parents Group, Montvale, NJ.
April 17, 2005	Methyl-B_{12}: Myth, Masterpiece, or Miracle? DAN! Spring Conference, Boston, MA.
November 8, 2004	Autistic Spectrum Disorders and Methyl-B_{12}: "Aka – Yes, Autism is a Treatable Disorder!", Berks County Autism Society, Reading, PA.
October 3, 2004	Biochemical Context and Clinical Use of One Specific Member of the Five-Member Vitamin B_{12} Family, Methyl-B_{12} (Methylcobalamin), DAN! Fall Conference, Los Angeles, CA.
April 18, 2004	Biochemical Context and Clinical Use of Vitamin B_{12}, DAN! Spring Conference, Washington, DC.
November 22, 2003	Biochemical Context and Clinical Use of Vitamin B_{12}, 4^{th} International Medical Conference on Autism in Quebec, Montreal, Quebec, Canada.
November 20, 2003	Methyl-B_{12} and Autism – Now a Treatable Disease, LINCA International Symposium on Autism, Mexico City, Mexico.
October 4, 2003	Case Presentation of Children with Autistic Spectrum Disorders, DAN! Fall Conference, Portland, OR.
May 18, 2003	A Practical Guide for Practitioners: Transitioning to a Practice that Focuses More and More on the Biomedical Aspects of Autism, DAN! Spring Conference, Philadelphia, PA.
May 17, 2003	Biochemical Context and Clinical Use of Vitamin B_{12}, DAN! Spring Conference, Philadelphia, PA.
October 25, 2002	Why Supplements? Because God and Mother Nature Say So, That's Why! Sponsored by Kirkman Labs at the DAN! Fall Conference,

	San Diego, CA.
February 11, 2002	The Potential Effects of Heavy Metal Chelation for Children Found to be on the Autistic Spectrum: Pros and Cons with Case Presentations, Berks County Autism Society, Reading, PA.
March 7, 1999	Creating an Enjoyable and Effective EPD Allergy Practice in the United States of America, International EPD Society Annual Symposium, Streatley, England.
March 7, 1999	Understanding and Utilizing the American and European Access Databases to Track Patient Progress and to Predict Potential Treatment Options Success or Failure Based on the Combined Databases Representing Over 10,000 Patients, International EPD Society Annual Symposium, Streatley, England.
April 21, 1997	Gathering the Data to Customize the Patient's Optimal Lifestyle Diet: Practical and Cost-Effective Clinical Laboratory Testing to Assess Vitamin, Mineral, Amino Acid, Fatty Acid and Organic Acid Status; Immune, Endocrine, and Gastrointestinal Function Profiles, Etc.: What to Order, What the Results Tell You, American Academy of Environmental Medicine Core Curriculum Annual Instructional Course, Part IV, Kansas City, Missouri.
April 2, 1997	Learn How to Feel Better, Have More Energy, Prevent Heart Disease, Deal with Nutritional Causes of Depression, Get Fewer Colds and Illnesses, Lose Weight and Keep It Off, Bloomburg University, Bloomburg, Pennsylvania.
January 7, 1994	Utilization of the Laboratory – Diagnosis and Treatment of Mentally Dysfunctional Patients, Carl C. Pfeiffer Treatment Center, Naperville, Illinois.
January 6, 1994	Update on Histamine Research as presented by the Histamine Neuroscience Research Group, Case Presentations – Demonstrating the Value of Nutritional and Environmental Treatment Modalities in Recalcitrant Patients, Carl C. Pfeiffer Treatment Center, Naperville, Illinois.
June 22, 1991	Preconception Care: Nutrient Actions and Interactions, Magaziner Medical Center, Cherry Hill, New Jersey.
May 19, 1991	Preconception Care: First Steps to a Healthy Start, Schizophrenia Foundation of New Jersey and Carl C. Pfeiffer Institute 9th Annual Scientific Conference, Princeton, New Jersey.
February 10, 1991	Preconceptual Planning for a Successful Pregnancy,

	Schizophrenia Foundation of New Jersey, Skillman, New Jersey.
February 3, 1989	Pyrroluria: The Treatable Mental Disease, Great Lakes College of Clinical Medicine, Dayton, Ohio.
October 2, 1988	Vitamin B_6: Friend or Foe, Schizophrenia Foundation of New Jersey, Skillman, New Jersey.

Invitations to Speak or Teach for 2011 and 2012:

March 2012	Association for Applied Psychophysiology and Biofeedback, Baltimore, MD.
May 2012	Autism One: HBOT and QEEG-Directed Neurofeedback Chicago, IL.
Summer/Fall 2012 (tentative)	American Medical Autism Board
Summer/Fall 2012 (tentative)	U.S. Autism and Asperger Association
Fall 2012 (tentative)	Autism Exit Australia

Publications and Poster Presentations:

James SJ, Cutler P, Melnyk S, Jernigan S, Janak L, Gaylor DW, Neubrander JA. Metabolic biomarkers of increased oxidative stress and impaired methylation capacity in children with autism. Am. J. Clinical Nutrition, Dec 2004; 80: 1611 – 1617.

Neubrander, James A.; PostScription: Compounding Pharmacies and the Successful Treatment of Autism. International Journal of Pharmaceutical Compounding, Nov/Dec 2005.

Deprey LJ, Brule N, Rafidi R, Sepheri S, Blank J, Neubrander J, James J, Hendren RL: Double-Blind Placebo Controlled, Cross-Over Trial of Subcutaneous Methylcobalamin on Behavioral and Metabolic Measures in Children with Autism: Preliminary Findings Poster Presentation at the Annual Meeting of the International Meeting for Autism Research (IMFAR), Montreal, June, 2006.

Deprey LJ, Brule N, Widjaja F, Sepheri S, Blank J, Neubrander J, James J, Hendren RL: Double-Blind Placebo-Controlled, Cross-Over Trial of Subcutaneous Methylcobalamin in Children with Autism: Preliminary Results Poster Presentation at the Annual Meeting of the American Academy of Child and Adolescent Psychiatry, San Diego, October, 2006.

Neubrander, JA: authored the original chapter on hyperbaric oxygen therapy for children with autism for Children with Starving Brains: A Medical Treatment Guide for Autism Spectrum Disorder; Jaquelyn McCandless, M.D.; 3rd Edition; Bramble Books, 2007.

Vojdani A, Mumper E, Granpeesheh D, Mielke L, Traver D, Bock K, Hirani K, Neubrander J, Woeller KN, O'Hara N, Usman A, Schneider C, Hebroni F, Berookhim J, McCandless J. Low natural killer cell cytotoxic

activity in autism: The role of glutathione, IL-2 and IL-15. J Neuroimmunol. 2008 Dec 15;205(1-2):148-54.

Neubrander, JA: authored the updated chapter on hyperbaric oxygen therapy for children with autism for Children with Starving Brains: A Medical Treatment Guide for Autism Spectrum Disorder; Jaquelyn McCandless, M.D.; 4th Edition; Bramble Books, 2009.

Rossignol DA, Rossignol LW, Smith S, Schneider C, Logerquist S, Usman A, Neubrander J, Madren EM, Hintz G, Grushkin B, Mumper EA. Hyperbaric treatment for children with autism: a multicenter, randomized, double-blind, controlled trial. BMC Pediatr. 2009 Mar 13; 9:21.

Thatcher, RW, North, DM, Neubrander, J, Biver, CJ, Cutler, S, DeFina, P. Autism and EEG phase reset: deficient GABA mediated inhibition in thalamo-cortical circuits. Developmental Neuropsychology, 34(6), 780-800, 2009.

Neubrander, JA: authored the chapters on hyperbaric oxygen therapy and methylcobalamin injections for children with autism for Cutting Edge Therapies for Autism, 2010-2011 and 2011-2012 Editions, Skyhorse Publishing. Currently both chapters for the 2012-2013 Edition.

Neubrander, JA: wrote the preface to the book Natural Medicine by Bonnie Camo, M.D., 2011.

Neubrander, JA: authored an article on hyperbaric oxygen therapy for children with autism for the Autism Science Digest, issue 2, the Journal of Autism One, 2011.

Neubrander, JA: co-authored with Jay Gunkelman, QEEG Diplomate, Michael Linden, Ph.D., and Cynthia Kerson, Ph.D, an article on QEEG-guided neurofeedback as a brain-based individualized evaluation and treatment for autism for the Autism Science Digest, issue 3, the Journal of Autism One, 2011.

Conferences/Meetings Attended:

November 16, 2011	The First International Conference on Autism Spectrum Disorders sponsored by Autism Exit Australia, Hobart, Tasmania, Australia.
November 14, 2011	The First International Conference on Autism Spectrum Disorders sponsored by Autism Exit Australia, Melbourne, Victoria, Australia.
October 30, 2011	U.S. Autism & Asperger Association World Conference, Seattle, WA.
July 23, 2011	The Third International Conference on Autism Spectrum Disorders sponsored by the American Medical Autism Board, Independence, OH.
May 27-29, 2011	Autism Recovery on a Budget: Empowering Parents, Autism One Conference, Lombard, IL.

April 2, 2011	Symposium on Autism: An Interdisciplinary Approach, Institute for Continuing Education with the New York City Health and Hospitals Corporation, New York City, NY.
September 30 to October 3, 2010	18th Annual Conference, International Society for Neurofeedback and Research, Boulder, CO.
September 11, 2010	2010 Fall Conference of the Pennsylvania Association of Naturopathic Physicians, Pittsburgh, PA.
May 29 & 30, 2010	Redefining Autism, Autism One Conference: Chicago, IL.
May 16, 2010	World Autism Conference Asia 2010, Hong Kong Academy of Medicine, Hong Kong.
May 8, 2010	Walsh Research Institute Sydney Outreach Conference, Sponsored by Bio Balance, Sydney, Australia.
March 27 & 28, 2010	The Second International Conference on Autism Spectrum Disorders sponsored by the American Medical Autism Board, Troy, MI.
March 20, 2010	International Academy of Oral Medicine and Toxicology Semi-annual Conference, Galloway, NJ.
January 30, 2010	Biomedical Treatments of Children With Autism, BAN Sweden Autism Conference, Stockholm, Sweden.
October 17, 2009	Strokes: From the ER to Rehab, Institute for Continuing Education with the New York City Health and Hospitals Corporation with the International Brain Research Foundation, New York City, NY.
September 3-7, 2009	17th Annual Conference, International Society for Neurofeedback and Research, Indianapolis, IN.
July 11 & 12, 2009	US Autism & Asperger Semi-annual Conference, Los Angeles, CA.
May 2, 2009	Walsh Research Institute Sydney Outreach Conference, Sponsored by Bio Balance, Sydney, Australia.
February 21, 2009	The First International Conference on Autism Spectrum Disorders, Sponsored by the American Medical Autism Board,

	Novi, MI.
November 2, 2008	The Injured Brain, 1199SEIU League Training in Collaboration with the International Brain Research Foundation, New York, NY.
October 17-19, 2008	Autismo y Trastornos de la Atencion, III Congresso Internacional, Ponce, Puerto Rico.
September 5-7, 2008	US Autism & Asperger Semi-annual Conference, Austin, TX.
August 28-31, 2008	16th Annual Conference, International Society for Neurofeedback and Research, San Antonio, Texas.
June 20, 2008	1st Annual Conference, NAA Kansas Chapter, Pittsburg, KS.
May 25, 2008	6th Annual Autism One Conference, Chicago, IL.
April 5, 2008	Defeat Autism Now 2008 Spring Conference, Cherry Hill, NJ.
March 13, 2008	ICIM with IHA Hyperbaric Oxygen Therapy Physician Workshop, Nashville, TN.
February 23, 2008	Autism Society of Illinois with NAA, Illinois Chapter, Chicago, IL.
February 14 to 17, 2008	US Autism & Asperger with Autism Today Biennial Conference, Orlando, FL.
November 9 & 10, 2007	National Autism Association Conference, Atlanta, GA.
October 27, 2007	Asociacion Latinoamerica de Medicina Hiperbarica y Instituto Politecnico Nacional y Tercer Congreso Intenacionale de Medicina del Deporte Rehabilitacion y Cuarto Congreso de Medicina Hiperbarica, Santorio Espanol, Mexico City, Mexico.
October 12 to 14, 2007	Defeat Autism Now 2007 Fall Conference, Anaheim, CA.
September 15 to 17, 2007	1st UDAAN Neural Repair and Neuro-rehabilitation Conference, Indian Institute of Technology, Hauz Khas, New Dehli,, India.
September 1 & 2, 2007	2007 Asian Autism Conference, The Hong Kong Academy of Medicine, Aberdeen, Hong Kong.

August 8 to 11, 2007	US Autism & Asperger Semi-annual Conference, Denver, CO.
May 27, 2007	Roadmap to Recovery, Autism One Conference, Chicago, IL.
May 19 & 20, 2007	Autism and Our Future, 1st Annual DAN! Europe Conference, Rome, Italy.
April 20 to 22, 2007	DAN! 2007 Spring Conference, Autism Research Institute Semi-Annual Symposium, Alexandria, VA.
March 10, 2007	Bridging the Gap and Natural Approaches for Autism Treatment,, Quad City Autism Coalition, Moline, IL.
March 5, 2007	Department of Medicine, Tokushima University, Tokushima, Japan.
March 2, 2007	International Hyperbarics Association Japan Conference, Tokyo, Japan.
January 19, 2007	Biomedical Approaches to Autistic Spectrum and Neurodevelopmental Disorders Conference, Co-sponsored by the Department of Cell Biology and Anatomy and the Faculty of Medicine, University of Calgary, Calgary, AB, Canada.
December 10, 2006	Autism for 2007: Encouraging Advances, Ariane Autism Association 1st Annual Conference, Paris, France.
August 12 & 13, 2006	2006 Asian Autism Conference, Aberdeen, Hong Kong.
August 9 & 10, 2006	US Autism & Asperger Conference, Park City, Utah.
May 28, 2006	Autism One Conference, Chicago, IL.
April 7 to 9, 2006	DAN! 2005 Spring Conference, Autism Research Institute Semi-Annual Symposium, Washington, DC.
November 13, 2005	National Autism Association Conference, Myrtle Beach, SC.
October 28, 2005	DAN! 2005 Fall Conference, Autism Research Institute Semi-Annual Symposium, Long Beach, CA.

October 14 & 15, 2005	Action Against Autism Conference, Royal College of Physicians, Edinburgh, Scotland, UK.
May 29, 2005	Autism One Conference, Chicago, IL.
April 15 to 17, 2005	DAN! 2005 Spring Conference, Autism Research Institute Semi-Annual Symposium, Boston, MA.
October 1 to 3, 2004	DAN! 2004 Fall Conference, Autism Research Institute Semi-Annual Symposium, Los Angeles, CA.
April 16 to 19, 2004	DAN! 2004 Spring Conference, Autism Research Institute Semi-Annual Symposium, Washington, DC.
November 21 & 22, 2003	4th International Medical Conference on Autism in Quebec, Montreal, Quebec, Canada.
October 3 to 5, 2003	DAN! 2003 Fall Conference, Autism Research Institute Semi-Annual Symposium, Portland, OR.
July 19, 2003	Mini DAN! Sponsored by the Autism Research Institute, Los Angeles, CA.
May 16 to 18, 2003	DAN! 2003 Spring Conference, Autism Research Institute Semi-Annual Symposium, Philadelphia, PA.
October 25 to 27, 2002	DAN! 2002 Fall Conference, Autism Research Institute Semi-Annual Symposium, San Diego, CA.
May 10 & 11, 2002	DAN! 2002 Spring Conference, Autism Research Institute Semi-Annual Symposium, Boston, MA.
January 25 to 27, 2002	Open Windows Essential Training Seminar, International Child Development Resource Center, Orlando, FL.
October 5 to 7, 2001	DAN! 2001 Fall Conference, Autism Research Institute Semi-Annual Symposium, San Diego, CA.
May 11 & 12, 2001	DAN! 2001 Spring Conference, Autism Research Institute Semi-Annual Symposium, Atlanta, GA.
December 14 to 17, 2000	A^4M Anti-Aging Conference and Exposition, 8th International Congress on Anti-Aging & Biomedical Technologies,

	Las Vegas, NV.
September 28 to 31, 2000	Add Life to Your Years and Years to Your Life, The American Academy of Environmental Medicine Thirty-Fifth Annual Symposium, Hilton Head, SC.
September 15 to 17, 2000	DAN! Conference 2000, Autism Research Institute 6th Annual Symposium, San Diego, CA.
October 7 to 12, 1999	Reaching New Heights in Patient Care, The American Academy of Environmental Medicine Thirty-Fourth Annual Symposium, Coeur d'Alene, ID.
October 5, 1999	DAN! Conference 1999, Autism Research Institute 5th Annual Symposium Cherry Hill, NJ.
September 24 to 26, 1999	Hard to Treat Chronic Diseases, XXXI International Congress, Great Lakes College of Clinical Medicine, Baltimore, MD.
November 6 to 8, 1998	Chart a New Course for Your Patients and Your Practice, The American Academy of Environmental Medicine Thirty-Third Annual Symposium, Baltimore, Maryland.
March 13 to 15, 1998	Brain Dysfunction, Dementias, Disorders and Detoxification, Great Lakes College of Clinical Medicine XXIX International Congress, Orlando, Florida.
October 11 to 15, 1996	Infectious Disease and Its Relationship to Environmental Medicine, The American Academy of Environmental Medicine Thirty-First Annual Symposium, Boston, Massachusetts.
September 20 to 22, 1996	Striving for Excellence in Medicine, Great Lakes College of Clinical Medicine XXVI International Congress, Milwaukee, Wisconsin.
May 9 to 12, 1996	Cardiovascular Disease and Treatment: A Comprehensive Perspective, American College for Advancement in Medicine Spring Conference, Orlando, Florida.
March 28 to 31, 1996	Third International Symposium on Functional Medicine, HealthComm International with the American Academy of Environmental Medicine, Vancouver, British Columbia, Canada.
March 23 to 24, 1996	Foundation for Advancement of Innovative Medicine Annual Symposium, New York City, New York.
November 2 to 5, 1995	Aging: Reducing and Coping with Its Effects, American College for Advancement in Medicine Fall Convention,

	Colorado Springs, Colorado.
September 29 to October 3, 1995	The Cutting Edge of Environmental Medicine, The American Academy of Environmental Medicine Thirtieth Annual Symposium, Tucson, Arizona.
April 20 to 23, 1995	Women's Health/Men's Health: Emerging Trends in Gender Related Health Issues, American College for Advancement in Medicine Spring Conference, New Orleans, Louisiana.
March 17 to 19, 1995	Pan American Allergy Society Annual Symposium, San Antonio, Texas.
November 13, 1994	The Histamine Neuroscience Research Group Second Annual Symposium, Miami Beach, Florida.
October 15 to 19, 1994	The American Academy of Environmental Medicine Twenty-Ninth Annual Symposium, Virginia Beach, Virginia.
February 24 to 27, 1994	The Twelfth Annual International Symposium: Man and His Environment in Health and Disease, Dallas, Texas.
October 9 to 12, 1993	The American Academy of Environmental Medicine Twenty-Eighth Annual Symposium, Reno, Nevada.
August 5 to 8, 1993	The Practicing Physician's Approach to the Difficult Headache Patient, Dannemiller Memorial Educational Foundation, Orlando, Florida.
June 18 to 19, 1993	Medical Management of Lipid Disorders Symposium, Washington, D.C.
May 5 to 6, 1993	The Sixth Annual Lymes Disease Scientific Conference, Jersey Shore Medical Center with the University of Medicine and Dentistry of New Jersey – Robert Wood Johnson Medical School, Atlantic City, New Jersey.
January 22 to 23, 1993	Nutritional Medicine in Medical Practice, University of California at Los Angeles, Santa Monica, California.
October 16 to 18, 1992	The Thirteenth International Conference on Human Functioning, College of Health Professions, Wichita State University, Wichita, Kansas.

Known References to Dr. Neubrander by Name in Publications, Presentations, or by Audio/Visual:

Books:

Natural Medicine by Bonnie Camo, M.D. (in press)

Jaquelyn McCandless, M.D.; Children with Starving Brains: A Medical Treatment Guide for Autism Spectrum Disorder; 4th, 3rd, and 2nd Editions; Bramble Books. ©2009, 2007, 2003.

Kenneth Bock, M.D.; Healing the New Childhood Epidemics: Autism, ADHD, Asthma and Allergies: The Groundbreaking Program for the 4-A Disorders; Ballantine Books, ©2007.

Jenny McCarthy; Mother Warriors, Dutton Publications ©2008.

David Kirby; Evidence of Harm: Mercury in Vaccines and the Autism Epidemic: A Medical Controversy; ©2005.

Jon B. Pangborn, Ph.D. and Sidney M. Baker, M.D.; Autism: Effective Biomedical Treatments; ©2005.

Doris J. Rapp, M.D.; Is This Your Child's World? How You Can Fix the Schools and Homes That Are Making Your Children Sick; ©1997.

Cutting Edge Therapies for Autism, Skyhorse Publishing; ©2010.

Julie Matthews; Nourishing Hope for Autism; Nourishing Hope, 3rd Edition, ©2008.

Christie Burnett; Finding Anthony; Lulu Publishing, ©2009.

Jennifer Hillman, Ph.D. & Stephen Snyder, with James Neubrander, M.D.; Childhood Autism: A Clinician's Guide to Early Diagnosis and Integrated Treatment, London and New York: Brunner-Routledge, ©2007.

Chantal Sicile-Kira; Adolescence on the Autism Spectrum: The Complete Guide to the Cognitive, Emotional, Social, Physical and Transition Needs of Teenagers with Autism Spectrum Disorders, New York: Perigee ©2006. Included is a "Food for Thought" vignette authored by Dr. Neubrander.

Patricia Lemer, MEd, NCC, MS Bus; book in progress with regard to Autism Spectrum Disorder projected release Fall ©2006.

Prevention Health Books; Healing with Vitamins, chapter "Quieting a Short-Circuited Brain" (quoted with regard to seizures); ©1996.

Interviews and Newsletters:

Comment January 2009: Due to the increasing numbers of interviews by various TV, radio, and autism organizations while attending conferences as a lecturer, in general details will no longer to be listed individually.

MY GOAL November 2008.

Kurt Woeller, M.D., Stillpoint Center for Integrative Medicine, October 2008.

Tommy Ellison's Story http://cbs3.com/health/Autism.Treatment.Childrens.2.836453.html, October 2008.

Autism One Radio; taped May 25, 2008.

Interview with Gary Null, October 2007.

The Pressure Point; Autism Issue Interview Special Summer Edition 2006: Autism Therapies in the Modern World – The Changing of the Guard; August, 2006.

Interview with Gary Null, July 2006.

Generation Rescue "Hall of Fame" number 11, current as of January 28, 2006.

Kurt Woeller, D.O.; "The Role of Methyl-B_{12} Therapy as a Treatment for Individuals with an Autistic-Spectrum Disorder"; Centers for Autism Related Disorders; January 11, 2006.

NOHA NEWS, Vol. XXXI, No. 1, Winter 2005/2006.

Althealth News; "Autism," December 1, 2005.

Stillpoint Center for Integrative Medicine; "The Incredible Benefits of a Specific Form of Vitamin B_{12}"; Nov/Dec 2005 newsletter.

Carolyn Garrett; "Emerging from Autism: Caitlin's Story;" International Journal of Pharmaceutical Compounding, Nov/Dec 2005.

Sandra Chapman; "Vitamin Could Be The Answer To Autism"; News Letter: The pride of Northern Ireland, November 15, 2005.

Stillpoint Center for Integrative Medicine; "Methylcobolamin (B12) Injections to Support Methylation Problems in Autistic-Spectrum Children"; November 2005 website addition.

Autism One Radio; live from National Autism Association conference, November 13, 2005.

Healthy Times Newspaper (Temecula, CA) – "Autism Is Treatable – The Incredible Benefits of a Specific Form of Vitamin B_{12}"; Oct/Nov 2005.

Autism One Radio; video from presentation at Action Against Autism's Treating Autism Conference, Edinburgh, Scotland, October 15, 2005, broadcast October 29, 2005.

WCBV-TV Boston channel 5; Dr. Neubrander cited as resource for Rocco Magliozzi autism story Sept 22, 2005.

Richard Deth, PhD; in presentation to NIEHS, Environmental Factors in Neurodevelopmental Disorders Conference, Bethesda, Maryland, August 25, 2005; included video of one of Dr. Neubrander's patients who significantly improved from Methylcobalamin treatment shown to those assembled.

WBAI: Dr. Majid Ali; July 12, 2005.

Kenneth Stoller, M.D.; presentation: Treating Autism: Misdiagnosis or Manipulation (or Treating Autism When We're Not Supposed to Know What is Causing It), Autism One Conference, Chicago, IL, May 2005.

Everyday Miracles Autism Support Network newsletter; "B_{12} Injections (Methylcobalamin)," May 2005.

Generation Rescue "Testimonial" mentioning Dr. Neubrander and MB_{12} therapy with regard to Andy, aged 6; mentioned May 2005.

Jaquelyn McCandless, M.D.; cited by Dr. McCandless in Autism One Radio interview of March 1, 2005, transcript published in Medical Veritas journal, Vol. 2, Issue 1, April 2005.

Lorene Amet, PhD; "Critical Evaluation of the Defeat Autism Now! (DAN!) Biomedical Intervention in Autism; A Parent Perspective. April 2005.

Autism Research Institute; Treatment Options for Mercury/Metal Toxicity in Autism and Related Developmental Disabilities: Consensus Position Paper, February 2005.

James Adams, PhD; presentation "Overview of Biomedical Research and Treatment for Autism." February 21, 2005.

Autism One Radio; live on Autism: Help, Hope, and Healing, February 8, 2005.

Environmental Working Group paper: Overloaded? New Science, New Insights about Mercury and Autism in Susceptible Children; original Report Release Date: 13 December 2004; acknowledgement to Dr. Neubrander.

Teresa Binstock; presentation at Mini-DAN November 2004.

Richard Deth, PhD; testimony "Molecular Aspects of Thimerosal-induced Autism" before the House Government Reform Committee; September 8, 2004 and October 5, 2004.

Autism Society of Berks newsletter; "What is Methyl B_{12};" Fall 2004.

FAIR Autism Media (Foundation for Autism Information & Research, Inc.) "Dr. James Neubrander discusses Methyl B_{12} in the treatment of Autism," September 2004.

Family Support & Resource Network newsletter, Spring 2004.

Autism Recovery Network newsletter, Issue 13, July 2003.

Autism Research Institute; Mercury Detoxification Consensus Group Position Paper, May 2001.

Professional Affiliations:

American Academy of Environmental Medicine.
American College for Advancement in Medicine.
American EPD Society (inactive status).
American Medical Association.
Alpha Omega Alpha Medical Honor Society.
Foundation for the Advancement of Innovative Medicine, New York and New Jersey Chapters (inactive status).
Great Lakes College of Clinical Medicine; now the International College of Integrative Medicine (inactive status).
International EPD Society (inactive status).
International Hyperbarics Association.
International Society for Neurofeedback and Research
Medical Society of New Jersey.
Middlesex County Medical Society.
Napier University Department of Biomedical Science, United Kingdom (inactive status).
Pan American Allergy Society (inactive status).
Schizophrenia Foundation of New Jersey (inactive status).
The Royal Society of Medicine.

Achievements and Awards:

National Registry of Who's Who; Life Member – Certificate #149228
Physician's Recognition Awards – 1980 to present.
Senior Medical Student Cardiology and Cardiovascular Surgery Award – 1975.
Alpha Omega Alpha Medical Honor Society – Elected 1975, active to date.
Who's Who in American Colleges – 1972.

Continuing Medical Education (Independent of CME's Associated with the Medical Meetings Shown Above):

Ongoing mini-CME credits	Various organizations and online credits (not listed here)
June 17, 2009	2008:2009 Physician Update: Cultural Competency

September 20, 1995	Nourishing the Body, Nurturing the Soul, Women's Wellness Workshop, Hopewell, New Jersey.
April 6, 1995	The Toxic Impact of Diet and the Environment on Your Special Needs Child, Hawthorne, New York.
February 5, 1995	Advancement in Clinical Nutrition, HealthComm International, New York City, New York.
August 6, 1994	Autistic and Behaviorally Disturbed Children Planning Session, Las Vegas, Nevada.
July 12, 1994	Management of Cutaneous Fungal Infections: Onychomycosis, Candidia and AIDS, Secaucus, New Jersey.
April 9, 1994	Alcoholism, Addiction and Codependency Awareness Program, Sixth Session, Carrier Foundation, Belle Mead, New Jersey.
April 2, 1994	Alcoholism, Addiction and Codependency Awareness Program, Fifth Session, Carrier Foundation, Belle Mead, New Jersey.
March 26, 1994	Alcoholism, Addiction and Codependency Awareness Program, Fourth Session, Carrier Foundation, Belle Mead, New Jersey.
March 19, 1994	Alcoholism, Addiction and Codependency Awareness Program, Third Session, Carrier Foundation, Belle Mead, New Jersey.
March 12, 1994	Tired or Toxic: A Look at the Principles of Environmental Medicine as They Apply to Fatigue as Seen by the Patient and Practitioner, Morristown Memorial Hospital with the Carl C. Pfeiffer Institute, Morristown, New Jersey.
March 5, 1994	Alcoholism, Addiction and Codependency Awareness Program, First Session, Carrier Foundation, Belle Mead, New Jersey.
November 17, 1993	Depression: Illuminating the Shadows,
October 21, 1993	Quarterway Houses as Treatment Alternatives, Carrier Foundation, Belle Mead, New Jersey.
October 20, 1993	Meeting the Challenge of Diversity: Transcultural Issues in Psychiatry, Carrier Foundation, Belle Mead, New Jersey.
October 14, 1993	Gender Differences in Schizophrenia, Carrier Foundation, Belle Mead, New Jersey.
September 23, 1993	Borderline Patients – Pathways to Health, Carrier Foundation, Belle Mead, New Jersey.
September 22, 1993	Addictions Across the Spectrum, Carrier Foundation, Belle Mead, New Jersey.
September 2, 1993	Mental Retardation and Psychiatric Illness, Carrier Foundation, Belle Mead, New Jersey.
August 19, 1993	Group Therapy with Personality Disordered Patients,

	Carrier Foundation, Belle Mead, New Jersey.
August 12, 1993	The Pharmacology of Stuttering, Carrier Foundation, Belle Mead, New Jersey.
July 15, 1993	Working With Adoptive Families, Carrier Foundation, Belle Mead, New Jersey.
July 1, 1993	Common Cutaneous Manifestations of Psychiatric Disease: Diagnosis and Treatment, Carrier Foundation, Belle Mead, New Jersey.
June 17, 1993	The Use of Restraints: Staff and Patient Perspectives, Carrier Foundation, Belle Mead, New Jersey.
May 23, 1993	Chemical Imbalances and Behavior Disorders, Morristown Memorial Hospital with the Carl C. Pfeiffer Intitute, Morristown, New Jersey.
May 10, 1993	Management Strategies for HIV Infection: The Second Decade The Academy of Medicine of New Jersey, the New Jersey State Department of Health, Division of AIDS Prevention and Control, and the Medical Society of New Jersey, Newark, New Jersey.
May 3, 1993	Comprehensive Management of the Menopausal Syndrome, University of Medicine and Dentistry (UMDNJ), New Jersey University of Health Sciences, Piscataway, New Jersey.
March 27, 1993	Headache in the Decade of the Brain, Temple University School of Medicine, Germantown Memorial Hospital, Germantown, Pennsylvania.
January 29, 1993	Histamine Metabolites in CSF of Patients with Schizophrenia: Their Relationships to Other Aminergic Transmitters and Ratings of Schizophrenic Behavior. The Effects of Famotidine, a Histamine H2 Receptor Antagonist, on Deficit Symptoms of Schizophrenics in an Open Label Trial. Morristown Memorial Hospital, Department of Psychiatry with the Carl C. Pfeiffer Institute, Morristown, New Jersey.
December 11, 1992	Clearing the Air: Addressing Nicotine Dependence in the 90's, The Academy of Medicine of New Jersey, Medical Society of New Jersey Headquarters, Lawrenceville, New Jersey.
November 18, 1992	Current Issues in Psychopharmacology, Carrier Foundation, Belle Mead, New Jersey.
October 31, 1992	Don't Treat the Diagnosis, Treat the Symptoms, Ram Kaminski, M.D., Mount Sinai Medical Center, Department of Psychiatry, New York City, New York, with Princeton Hospital, Princeton, New Jersey.
September 16, 1992	HIV Disease: Clinical Aspects and Nutritional Considerations, The Academy of Medicine of New Jersey, New Brunswick, New Jersey.
June 7, 1990	Brain, Biology and Behavior,

	Carrier Foundation, Belle Mead, New Jersey.
March 29, 1990	The Next Stage in Mediating Schizophrenia, Carrier Foundation, Belle Mead, New Jersey.
December 21, 1989	Psychopathology in Dually Diagnosed Adolescents, Carrier Foundation, Belle Mead, New Jersey.
July 20, 1989	AIDS: Managing the Psychosocial Impact, Carrier Foundation, Belle Mead, New Jersey.
July 6, 1989	Seasonal Depression: Phototherapy and Sleep Deprivation as Treatments, Carrier Foundation, Belle Mead, New Jersey.
June 1, 1989	Brain Grafting: Can We Be Rejuvenated? Carrier Foundation, Belle Mead, New Jersey.
May 25, 1989	Panic Disorder: Biology and More Effective Therapy, Carrier Foundation, Belle Mead, New Jersey.
April 20, 1989	Rape and Incest: Psychological Issues, Carrier Foundation, Belle Mead, New Jersey.
April 13, 1989	Brain Function in Schizophrenia, Carrier Foundation, Belle Mead, New Jersey.
April 12, 1989	Activation of Post-Traumatic Stress Disorder; Terrorism – Disaster – Abuse – War, Carrier Foundation, Belle Mead, New Jersey.
March 16, 1989	Research Update: Substance Abuse and Addiction, Carrier Foundation, Belle Mead, New Jersey.
March 2, 1989	Generic Medications: The Pros and Cons, Carrier Foundation, Belle Mead, New Jersey.
February 16, 1989	When a Child Dies, Carrier Foundation, Belle Mead, New Jersey.
February 2, 1989	Non-Neuroleptics in Treatment of Psychosis, Carrier Foundation, Belle Mead, New Jersey.
January 19, 1989	The Impact of Bereavement and Grief on the Immune Function, Carrier Foundation, Belle Mead, New Jersey.
December 20, 1988	The Medical Evaluation of Depression, The Medical Center at Princeton, Princeton House, Princeton, New Jersey.
November 15, 1988	Orthodox and Unorthodox Psychotherapy, The Medical Center at Princeton, Princeton House, Princeton, New Jersey.
November 3, 1988	Indications for Family Therapy, Carrier Foundation, Belle Mead, New Jersey.
October 20, 1988	Music Therapies with the Organically Impaired, Carrier Foundation, Belle Mead, New Jersey.

October 18, 1988	Syndrome of Dopamine Depletion and Dopamine Activation, The Medical Center at Princeton, Princeton House, Princeton, New Jersey.
October 13, 1988	Polymyalgia Rheumatica/Temporal Arteritis: The Great Imposters, Carrier Foundation, Belle Mead, New Jersey.
October 12, 1988	Psychiatrists and the Treatment of Addictions: Perceptions and Practices, Carrier Foundation, Belle Mead, New Jersey.
September 29, 1988	AIDS: CNS and Psychiatric Manifestations, Carrier Foundation, Belle Mead, New Jersey.
September 20, 1988	The Neuropsychiatric Spectrum of Acquired Immune Deficiency Syndrome, The Medical Center at Princeton, Princeton House, Princeton, New Jersey.
September 13, 1988	Research Update: Electroconvulsive Therapy, Carrier Foundation, Belle Mead, New Jersey.
September 1, 1988	Research Advances in Treating Alcoholism, Carrier Foundation, Belle Mead, New Jersey.
August 18, 1988	Families of Adolescent Adults, Carrier Foundation, Belle Mead, New Jersey.
August 4, 1988	New Developments in Substance Abuse, Carrier Foundation, Belle Mead, New Jersey.
July 21, 1988	Working with Difficult Geriatric Patients, Carrier Foundation, Belle Mead, New Jersey.
July 14, 1988	Assaults on Staff by Psychiatric Patients, Carrier Foundation, Belle Mead, New Jersey.
June 16, 1988	This Is Me – Art Therapy with Anorexics, Carrier Foundation, Belle Mead, New Jersey.

Research Projects (active and inactive):

Measurement of proprietary biomarkers for children with autism in collaboration with Northeastern University and Richard Deth, Ph.D.

Proposed study to establish the Parent Designed Report Form's "Pegboard Effect" format as an effective tool by mathematically assigning power to anecdotal observations. The purpose is to capture effective medical and therapeutic treatments, of all types, that are presently being overlooked because they do not meet statistical significance by using the current paradigm that depends upon the double-blind, placebo-controlled, crossover model.

Y-Axis Rating Scale (YARS): a novel approach of documenting patient responses to multiple therapeutic interventions.

Phase One: QEEG data collection by James A. Neubrander, M.D. to determine the outcome of QEEG studies with autism as it relates to multiple treatments including, but not limited to methylcobalamin, hyperbaric oxygen, and advanced neurofeedback techniques. Chelation effects (antioxidant?) anticipated to follow.

Advisor to the Institute for Neurodevelopmental Disabilities Interventional Research Activities (INDIRA Project), New Dehli, India. Formal clinic and hospital-based studies are being designed to combine methylcobalamin therapy, hyperbaric oxygen therapy, stem cell therapy, and physical medicine.

Proposed study with Tappan Ayuda, Ph.D.: Design an IRB approved study to document the safety and effectiveness of the HBOT protocol first implemented on a large scale by Dr. Neubrander. This protocol involves two 1.5 hour treatment sessions per day with no less than a six hour break between sessions with "effectively inspired oxygen concentrations" ranging from 38% to 50% at 1.3 atmospheres of pressure for 30 consecutive days. Monitoring occurs at the 10^{th} day, 30^{th} day (endpoint), and three weeks post endpoint.

Planning phase with International Hyperbaric Association for a study to document the safety and effectiveness of treatments using as much as three hours per day with split sessions using 1.3 to 1.5 atmospheres and oxygen concentrations varying between 38%-100%. Various phases of the study will be designed for traumatic brain injury, autism, Alzheimer's, stroke, and other neurodevelopmental disorders.

Effects of high dose, low volume, subcutaneous administration of methylcobalamin on children with autism. Comparative study of the effects of methylcobalamin from the multiple routes of administration including nasal spray (ongoing in-house clinical study since May, 2002).

Clinical effects of HBOT on children with autism: High pressure high oxygen concentration and low pressure low oxygen concentration (ongoing in-house clinical study since December 2005).

Participant in double-blind, placebo-controlled, multi-center study for children with autism using low pressure low oxygen concentrations: Primary investigator Dr. Dan Rossignol. Study completed March 2007. (BMC Pediatr. 2009 Mar 13;9:21.)

Participant/advisor for the M.I.N.D. Institute methylcobalamin study for children with autism, July 2004 to publication. (study completed)

Advisor to the International Brain Research Foundation's Autism Project. Appropriate studies and funding issues are to be discussed March, 2004 at the Torino, Italy Traumatic Brain Injury Think Tank. (inactive)

Measurement of thiols and mRNA status in children with autism using PCR in collaboration with Northeastern University and Richard Deth, Ph.D. (inactive)

Planning and data gathering phase with Dr. Richard Deth and ARI for a study to document methylcobalamin and methionine synthase effects on children with autism and autistic spectrum disorders. (inactive)

Proposed study with Stephanie Cave, M.D. to determine the possible relationship of thyroid markers and autism. (inactive)

Proposed study with parents of autistic children from France to participate in our clinic to document safety and effectiveness of low pressure low oxygen concentration HBO therapy so the medical governing body will allow soft chamber use of HBOT in local clinics and in the homes of parents in France. (inactive)

Enzyme Potentiated Desensitization (EPD) five year study. (inactive)

- To determine the possible beneficial results of EPD immunotherapy for various medical conditions in the United States.
- Comparison of the results of EPD immunotherapy between the United States and Europe.

Free radical pathology in relation to vascular disease: use of nutraceuticals, medications, and chelation therapy. (inactive)

Kirkman enzymes containing Isogest: Clinician participation in pre-marketing safety study. (inactive)

Nutritional and free radical effects on fibrodysplasia ossificans progressiva. (inactive)

An analysis of cost containment in medicine in a multi-center study involving the United States, United Kingdom, Denmark, and New Zealand. (inactive)

Personal Interests:

Domestic and international travel, scuba diving, coral and saltwater fish, Latin and ballroom dancing, fine dining and fine wines, gourmet cooking, golf, flying, comedy, computer graphics, collecting Far Side cartoons, Herman cartoons, and cookbooks, developing and teaching memory techniques.

LIST OF SERVICES PROVIDED

Services not only for the patient, but also available for the entire family

<u>IMPORTANT NOTE</u>: in addition, our services are <u>*not limited*</u> to Autism Spectrum Disorders. *We treat hundreds of other disorders* that can benefit from the same types of treatments listed below.

Often I am asked what types of biomedical services I offer or am able to facilitate at my clinic. In general, if you read about a test and/or treatment in the *Defeat Autism Now Scientific Consensus Report* and/or in Dr. Jaquelyn McCandless's Book, *Children With Starving Brains,* or Dr. Bock's book, *Healing the New Childhood Epidemics*, I will be able to do these tests and treatments at my office or enable you to get them done from one of my colleagues when I do not offer a service.

The following list includes many of the things I do. However, *<u>it is incomplete</u>* and will never be up-to-date because I always am evolving in what I have to offer my patients and their families.

Just to be clear, not only does my clinic offer services to children on the autism spectrum and their families, it also offers the same types of services to children and adults who may benefit for any other type of disease or disorder.

1. **Methyl-B_{12}** injections to increase methylation and transsulfuration (e.g. glutathione) biochemistry, two factors critical to improving executive function, speech and language, and appropriate emotion and socialization skills. Methyl-

B_{12} seems to unlock the areas of the brain that are required to verbalize and communicate effectively. It is not uncommon to see improvements in expressive, receptive, and conversational language as well as the ability to make longer sentences that include pronouns, adjectives, adverbs, etc! Methyl-B_{12} is known to increase eye contact, focus, attention, awareness, comprehension, and the ability to understand abstract ideas and concepts. The children become more tolerant of change, transition much more easily, and become more flexible. They are able to communicate their wants and needs more effectively. Methyl-B_{12} improves their ability to stay on task and the ability to follow more complex commands. It helps with imaginative play, imitation skills, and engagement with others. Often they become more in touch with their feelings and the feelings of others. Interests are widened, the children become more inquisitive and they try new things. They become more self confident, opinionated, and their need to be independent is heightened. The children learn more easily, their memory improves, and things that parents did not even know their children knew are now expressed to their parent's great surprise! The children become much more affectionate, cuddly, and loving and they have many more good days at home and school than they ever did before. In addition, methyl-B_{12} is known to improve the immune system, decrease allergic responses, and it often helps appetite, aids in increasing weight, and frequently helps gross and fine motor skills. To date, I *have prescribed and monitored well over a million doses of methyl-B_{12}.* I have used every route of administration (oral, sublingual, transdermal, nasal, intramuscular, intravenous, and subcutaneous) *and have documented that the only route of administration that consistently produces significant clinical benefits are from (painless) subcutaneous injections*. Though most parents enter my practice very fearful of giving the shots, after administering only one or two injections, 9 out of 10 of them say that this is the easiest thing that they do! When parents know what to look for and how to evaluate whether or not the shots are working, approximately 94% of parents are able to "*undeniably document*" numerous benefits they have witnessed to occur during the first six weeks of treatment. *Unique to my practice* is the fact that during the six week initiation phase I do not let parents make any other 'biomedical' changes to their child's treatment program. By this I mean parents are not allowed to add anything new or take anything away from what they are already doing, nor are they allowed make any modifications to any treatments already in process, e.g. they cannot increase or decrease anything they are already giving. Therefore, when parents evaluate the progress they see in their child, everything that occurred within the six week period of time will have been from the addition of methyl-B_{12} therapy and not from other things that they may have added simultaneously (the most common way biomedical treatments are started in most other practices). *Also unique to my practice* is the evaluation process I use to document clinical progress from methyl-B_{12} therapy. Parents need to "*know for sure without any lingering doubt*" that methyl-B_{12} really is working for their child. In order to do this, I use a form called the *Parent Designed Report Form.* It works much more effectively than any other evaluation tool because it was you, the parents who created its content and it was you, the parents who determined the language that you wanted it to use so that you could tell your entire story and do it your way.

The *Parent Designed Report Form* is the only evaluation tool available anywhere that allows "*anecdote*" to become "*scientific*" by attaching "*numbers/value*" to what you are able to document "*undeniably*" that you see occur during the "*no other changes made*" six week period of time. The *Parent Designed Report Form* is the only evaluation tool that "*validates*" what you, the parents see to occur during the evaluation period *rather than invalidate* your observations by calling them "anecdote". The *Parent Designed Report Form* is the only evaluation tool that "*recognizes*" that only you, the parents, are able to see what occurs in your child "*24/7-365*" and therefore "*your observations*" are powerful "*scientific tools*", not pieces of worthless information from desperate parents willing to believe any fairy tale out there. *In summary, the Parent Designed Report Form* is the only evaluation tool anywhere in the world that *makes anecdote scientific* and puts the power of anecdote into the hands of the parents who are no longer willing to accept from professionals or the scientific community that their observations are meaningless! Most importantly, *it allows the tremendous power of methyl-B_{12} treatment to be initiated now rather than being delayed* until someone designs the perfect study that will take years to finish in order to prove what you, the parents, already know to be 'undeniably true'!

2. **Folate receptor autoantibodies** diagnosis and subsequent treatment options. This is vital information necessary to complete treatment options for three of the most critical biochemical pathways that we find affected to some degree in the majority of children on the autism spectrum: methylation, transsulfuration, and the 'reduced' forms of the folic acid family. Antibody formation to folate receptors is an autoimmune phenomenon that blocks methylfolate from crossing the blood brain barrier in order to enter neurons. *In our practice we find approximately 2/3 of children have such antibodies*. In addition, folate receptor autoantibodies are believed to be more frequent in children who have seizure disorders. On a related side note, it is important to realize that studies demonstrate approximately 1/3 of children on the spectrum are affected by seizures. Such seizures are mostly nocturnal, usually not witnessed by parents, and typically not severe enough for parents to even notice. However, they are there, affect the children, and should be treated.
3. **Mitochondrial "disorder/distress" screening and treatments.** Mitochondrial "distress" is not the same thing as severe mitochondrial *disease* which is *referred* to specialty clinics that handle such severe cases of mitochondrial problems. Mitochondrial 'distress' can be considered a phenomenon in which the mitochondria cannot meet the body's demand to make enough ATP, whether all the time or just intermittently when the body's demands are higher than usual. We find such 'stress' on the mitochondria to be much more common than was currently believed to be present in children with autism. Once found, effective treatments can be implemented. Mitochondrial distress/disorder (and disease) is found to be more frequent in children who have seizure disorders. As stated above, studies show that approximately 33% of children on the spectrum have some type of seizure activity. The take-home message is that just because parents have never witnessed any type of seizure activity in their child does not negate the fact that if their child was evaluated under controlled scientific conditions, 1/3 of them would test positive.

4. **Comprehensive nutritional testing and treatment** is based on laboratory results when parents want such testing to be completed and when finances are not limited. However, when finances are limited, modified testing can be ordered and the subsequent treatment programs I will prescribe will be based on the results of the limited tests and over 30 years of experience I have had in the field of nutritional medicine. During that period of time I have interpreted thousands of nutritional tests, or related tests that affect nutritional status, and can state that children on the autism spectrum have many similarities in their deficiency patterns or patterns of nutritional imbalance. The good news is that for the most part, these deficiencies and imbalances can begin to be treated without extensive testing and later, if problems still exist, then more specific testing can be ordered. Treatments commonly include appropriate supplementation with vitamins, minerals, amino acids, essential fatty acids, digestive enzymes, pre and probiotics, herbal agents, etc.
5. **Dietary recommendations, testing, and treatments for all types of diets:** casein-free gluten-free diet (CFGF); specific carbohydrate diet SCD); food allergy diets and non-allergic food intolerance/sensitivity diets; elimination/rotation diets; yeast-free diet; Feingold and related-type diets (salicylates, phenols, food additives of all types, etc); low oxalate diet (LOD); Gut and Psychology Syndrome diet (GAPS); Body Ecology diet (BED); fermented foods diet, etc. Each of the diets shown above have the potential of helping key issues in specific individuals. Finding the *right diet* often requires professional help. Knowing what diets have tests that can be ordered, what tests are most likely to be helpful, and whether the information gained from the test will justify the cost almost always requires a professional's advice. In addition, it is very important to consult with a professional to make sure that foods that 'test positive' are not 'good foods' that really do not need to be eliminated, or if they must be eliminated that they are not eliminated for periods of time longer than required. It is very common for a parent to obtain a food allergy or food hypersensitivity test and eliminate all the 'flagged foods' or eliminate them for a year or more when this is not necessary or far too long to avoid the food. Just as common, if not more common is when parents obtain a test for 'allergies or hypersensitivities' that comes back with 25-33% of the foods marked as moderately to significantly abnormal with a report that says to eliminate the foods. Accurate interpretation of such a test requires a professional who knows how to differentiate between a 'leaky gut pattern', a GI problem that does not require all the foods be eliminated, or a true food hypersensitivity problem that will require at least *some* of the foods be eliminated, though *not necessarily all* of them.
6. **Gastrointestinal issues – diagnosis, treatment, and when necessary, an appropriate referral**. Children on the spectrum have some type of GI symptoms more than 50% of the time. The common symptoms include loose stools ("mushy"; "like mashed potatoes"), diarrhea, constipation, infrequent bowel movements, bowel movements that are voluminous for the size of the child ("can fill up much of the toilet bowl"), extremely foul smelling stools ("can clear the room"), stools with atypical or varying colors, much undigested food, very hard or distended protruding abdomens ("looks pregnant"), gas, bloating, abdominal pain, "posturing", etc. In addition, scientific studies have

demonstrated that there are as many neurons in the GI tract as there are in the brain, something now referred to as 'the gut-brain connection'. The way this applies to children with autism is that frequently their GI problems are expressed behaviorally or in other ways that do not seem to be related to the GI tract. Examples include, but are not limited to aggression, head-banging, biting, kicking, fits of screaming or outbursts for no apparent reason; unexplained behavioral changes that come on suddenly and then can leave just are quickly, serious sleep disorders, hyperactivity, stimming, etc. Certain anaerobic bacteria from the Clostridial family produce proprionic acid which has been shown to turn normal rats into autistic rats. Many other types of aerobic bacteria also produce organic acids or have direct inflammatory effects that also affect children on the spectrum. This is a process called 'dysbiosis'. A few of the 'dysbiotic' bacterial species commonly seen from families other than the Clostrial family include, but are not limited to Klebsiella, Citrobacter, Pseudomonas, Proteus, etc. It is important to know if there are enough 'beneficial' bacterial species present and if not treat using "pro"biotics. It is also important to know if there is enough "nutrition, food, and fiber" present for the beneficial bacteria to thrive upon. If not, treatment with "pre"biotics is indicated. Besides absence, excess, and imbalance of anaerobic and aerobic bacteria, many different genus or species of yeast are often present. Also, it is not uncommon to find parasites in the children's GI tract when tested. In addition to determining the types of organisms that are living within the child—good types or bad types or types that are out of balance--it is also important to determine whether the child has digestion/absorption problems; gastrointestinal inflammatory and gastrointestinal immune problems including whether the child produces too much or too little protective 'secretory IgA' (the intestine's first line of defense), or if the child's body is consuming too much protective 'secretory IgA' due to an intestinal inflammatory or infectious process; gastrointestinal metabolic problems; proper fecal pH balance; the ability to process fats; the amount of bile and digestive enzymes present; and whether the child has a "leaky gut pattern" (intestinal permeability which triggers the immune system to react in a manner that often produces negative symptoms). When symptoms are severe enough and not resolved by the more standard and conservative treatments I use in my office, I will refer patients for a comprehensive workup that may include an endoscopy, colonoscopy, and pill cam procedure that has a 'camera' pass through the small intestine. Each of these procedures is done in order to diagnose autistic enterocolitis (AE) and lymphonodular hyperplasia (LNH) vs. other types of bowel disorders.

7. **Hyperbaric oxygen therapy ("HBOT")** has been shown to work well for many children on the autistic spectrum, and if they have been shown to respond to one of my methyl-B_{12} treatment protocols, over 90% of that group will also respond to hyperbaric oxygen therapy when parents monitor their child's progress by using the *HBOT Parent Designed Report Form* they have created. In my practice I use both hard chamber treatment sets (100% oxygen concentrations delivered at high pressures performed in the clinic) and soft chamber treatment sets (oxygen concentrations less than 100% produced by oxygen concentrators and delivered at low pressure from 'portable' hyperbaric units that can be used in the clinic or at home). Both types of treatment work

well if done according to protocols I have perfected since I first began using hyperbaric oxygen treatments for patients with autism in December 2005. Since that time I have monitored an estimated 100,000 treatment hours from approximately 800 children with autism. The most common improvements I can document from parents who followed my protocols exactly and evaluated their child's changes with the *HBOT Parent Designed Report Form* are as follow: increased language (expressive, receptive, conversational, sentence length and complexity); increased level of awareness and understanding; more opinionated, independent, and self-confident; increased eye contact and more "present"; increased degree of socialization, imaginative and interactive play, and engagement with others; more in touch with feelings (self and others); increased ability to make requests known by several methods (language, gestures, etc.); increased flexibility, decreased frustration, easier transitions; improved GI symptoms, better stools and being able to be potty trained, often 'spontaneously' on their own without encouragement by their parents!

8. **Detoxification and chelation therapy** have the potential to be a valuable treatment for many children. However, its 'potential' need and 'documented' benefits have been largely exaggerated, both by professionals and parents alike. The alarm and fear that websites, chat rooms, and parent blogs have created is nowhere close to what I have been able to document in my practice after doing this with hundreds of children over the last 15 years. The furor that exists as to what is the best way to chelate, and often promoted as the 'only' way to chelate, has at times reached charismatic levels with the various factions getting no less involved and emotionally charged than what we see when one talks about religion or politics! Still, for any *individual* child, considered to be a *unique* being, chelation *may* play a valuable role in that child's overall set of treatment modalities to move him or her towards recovery. I do not believe in blindly chelating a child (or adult). However, if key laboratory *screening tests* indicate that chelation "may" be a valuable treatment option, and if parents decide they want to chelate, I will then begin to take the next steps with them. Those critical steps include full informed consent by ***both*** the mother and father, a detailed discussion as to the pros and cons of chelation, what are the 'knowns and unknowns' of chelation itself as well as what will occur with the chelation process we will be using, its potential benefits vs. its relative risks, the costs involved to frequently monitor various tests for safety (liver, kidney, bone marrow), and the steps required to prevent getting into trouble by being too aggressive and not repleting the essential minerals that will also be removed along with the toxic minerals. Should we come to a mutually acceptable understanding, only then will I begin the chelation process with the family for their child. At that point, I will discuss with the family the method of chelation that I believe will be the best one to use. This decision is based on many factors, e.g. the family's financial state, where they live relative to my clinic, their belief system and/or fears, their ability to obtain safety tests on a regular basis, and knowledge base they have relative to everything known about the various options I can use to chelate their child. Such options include, but are not limited to: oral DMSA; oral DMPS; intravenous DMPS; intravenous CaEDTA; suppository forms of DMSA, DMPS, or EDTA; transdermal DMPS

or DMSA; the "Cutler method" that requires no lab tests; and more natural methods of chelation, e.g. supplements, glutathione, herbal agents, etc.

9. **Allergy and allergy-like diagnoses and treatments.** Most common are food and inhalant ("airborne, environmental") allergies. In addition, we can diagnose and treat cytotoxic and chemical sensitivities whose symptom complexes are similar to allergies, though not truly "allergic" by the standard definition. Not only do allergies cause significant symptoms, food allergies represent a very important reason children on the autism spectrum develop a "leaky gut", something that complicates the GI issues commonly seen with this subset of children. According to the Boris/Goldblatt study, children with ADD/ADHD and autism demonstrated significant regressive symptoms that directly paralleled the officially reported pollen counts. In addition, the symptoms that affected the brain did not require that the children have classical allergy symptoms. This confuses many parents and clinicians. To understand why this occurs, it is important to understand that mast cells are sensitized to many different substances and when they come into contact with a triggering substance, they release histamine. Such substances not only include pollens from weeds, trees, and grasses, but also include molds, animal dander, insect droppings, and foods. Once released into the bloodstream, histamine binds to various types of histamine receptors. When a person has histamine receptors in the eyes and nose, they are bothered by classical allergy symptoms. When a person has histamine receptors in esophagus and stomach, they are bothered by acid reflux ("heart burn"). When a person has histamine receptors in the brain, they are bothered by many different types of regressive symptoms. That is why persons without 'nose and eye receptors' did not regress from pollens but did regress because they had 'brain histamine receptors'. One specific treatment I use for <u>inhalant and food</u> allergies is *LDA injections* ("low dose antigens"), a treatment that works well with children on the autistic spectrum and one that typically isn't severely compromised, in my experience, by dietary issues. There are only a few physicians in the country that use this method of desensitizing patients to airborne (inhalant, environmental) allergies because it requires specialized training by the physician. The reason I have switched from the classical method of desensitizing to LDA is because LDA only requires between 10-16 shots over a three year period of time as compared to the numerous shots necessary from classical desensitizing. It addition, LDA can be used to desensitize for food allergies and hypersensitivities as well as chemical sensitivities, none of which conventional allergy treatments can accomplish. One of the benefits I offer family members who also suffer from allergies are LDA shots at a significant family discount rate.
10. **Immune/autoimmune system testing, diagnoses and treatments.** As scientific information accumulates, the evidence appears to support the hypothesis that the immune system is involved autism, though how much and to what degree is unknown. Therefore, looking at various immune and autoimmune system tests can be valuable, especially when considering what treatments may be the best ones to initiate or in what order to begin using them. This area of interest for autism, as well as many other disease processes that involve the immune and autoimmune systems, is too extensive to discuss here more than briefly. Many tests can be ordered, though what most of the positive

test results mean and what treatments may effective to treat them is still unknown. Some of the treatments that have stood the 'test of time' by those of us who treat large numbers of children on the autism spectrum, at least from the safety perspective, include various agents that boost different parts of the immune system, things like low dose naltrexone (LDN), spironolactone, minocycline, Singulair, short-term "targeted' high dose steroids (oral or IV), etc. Antiviral therapy has also been used safely with varying degrees of success or failure for suspected or documented viral infections. With the exception of LDN, if prescribed such agents are used sparingly and for short periods of time. In addition to the types of therapies just discussed, new possibilities are always coming to the forefront that may or may not prove safe or effective and often are things that are not available to be used in the United States.

11. **PANDA's diagnosis and treatment** belongs to the immune/autoimmune category of problems. However, because it is quite specific and problematic for so many children on the autism spectrum, it is listed here as a separate entity. PANDAS stands for **P**ediatric **A**utoimmune **N**europsychiatric **D**isorder **A**ssociated with **S**treptococcal Infections. It was first described by Susan Swedo, M.D. from the National Institute of Mental Health. The disorder is characterized by a child having exacerbation of obsessions or tics. Comorbid symptoms include compulsions, strange body movements (choreiform), emotional lability, personality changes, age inappropriate behaviors, separation anxiety, oppositional defiant disorder, tactile/sensory defensiveness, ADHD, major depression, marked deterioration in handwriting, daytime urinary frequency/enuresis, and occasionally anorexia. The problem with this disorder is that most of the symptoms associated with it also represent many of the classical symptoms of autism and to know what is autism vs. what is PANDAS vs. what is a mixed presentation requires a professional knowledgeable in this field. The diagnosis is established from the history, the chronological sequence as to when the symptoms appeared or became more quiescent, the season of the year, other associated factors, e.g. strep infections at school or at home, etc. There are specific tests that help 'strengthen' the likelihood of the diagnosis but to date no test can actually diagnose whether a person has PANDAS or not. That is why professional help is necessary. The treatments include antibiotics, steroids, and IVIG.
12. **Hormonal evaluations** is an area of interest for many children on the spectrum, especially if signs of precocious puberty are seen on physical exam, around puberty, or at any age when a child is exhibiting certain behaviors, things like severe aggression, self-injurious behaviors, explosive tendencies, etc.
13. **Neurotransmitter evaluations** are another area of interest for many children on the spectrum. Abnormalities or imbalances can occur at anytime with any symptom or symptom complex. However, hyperactivity, stimming, excitability, and sleep disorders are just a few of the reasons that neurotransmitters may be tested for and treated. Treatments include more natural mild herbal agents to conventional medicines.
14. **Herbal treatments** are frequently recommended to accompany many of the other treatments.

15. **Intravenous treatments** that I use in my clinic include glutathione, phosphatidylcholine, vitamins and minerals, regimens that support the immune system, steroid, secretin, and IVIG (intravenous gamma globulin).
16. **QEEGs and neurofeedback:** Quantitative EEGs (QEEG) are able to demonstrate what part of a child's brain is producing too much or too little activity (power, voltage) relative to normative databases comparing a specific child or adult to thousands of other normal age matched children and adults. It also is able to demonstrate where the brain wave activity connects too little or too much. By performing an EEG and then running it through one or two QEEG normative databases, we can subtype the child's brain map pattern and see the areas of the brain that correlate to the symptoms being elicited by the child. For example, we can look at a QEEG and see the areas of the brain affected that result in symptoms like poor receptive and expressive language, focus and attention problems, memory and learning difficulties, obsessiveness, anxiety, social deficits, inappropriate behaviors, just to name a few. From the QEEG pattern, medications and/or "neuroceuticals" (nutraceuticals that work on the brain) can be recommended or prescribed. Specific prescriptions for neurofeedback can be written from the electrical map in order to retrain the abnormal brainwave patterns back to normal through proven operant condition techniques. Neurofeedback is a non-invasive treatment that has the patient play 'mind games' on the computer while the neurofeedback technician adjusts the 'reward and inhibit' settings. By doing this, the brain automatically resets itself to the correct power and frequencies desired and the associated symptoms lessen or resolve. Though the process of neurofeedback is slow, it has the proven potential to make changes that are permanent, not temporary. The most studied disorder for neurofeedback is attention deficit hyperactivity. For this problem, neurofeedback has been shown to work as well as medications if the subject is trained long enough by a qualified provider. The second most studied disorder for neurofeedback training is epilepsy/seizures. For this disorder, neurofeedback has been shown to be almost as effective as medications and therefore this type of treatment may be a good non-invasive option for patients who do not have the serious types of seizures, e.g. grand mal seizures. Alternately, adequate neurofeedback training may allow anticonvulsant medications to be reduced over time, though not necessarily discontinued.
17. **Speech, language, swallowing, and sensory modalities:** Since April 2009, I have been referring patients to Maria McNish and her company, Advanced Therapy of America (ATA), a full service entity that offers comprehensive speech and language assessments, multiple types of speech therapy including PROMPT, family training to teach parents how to work with their children at home, interactive socialization training with groups of children matched for age and/or degree of involvement, sensory, motor and auditory training, eating and swallowing therapy including pill swallowing, as well as techniques including "vital stimulation". Maria is by far one of the best speech therapists and 'bubbly personalities' I have ever had the pleasure to work. It has not been an uncommon event for me to hear how much faster their children are progressing under the care of her and her team. At this time, Maria and I plan on offering mini-seminars to help parents learn what it takes to reach their desired goals for their children more quickly. In addition, Maria and I are offering what we call

'intensives'. This involves parents staying within the local area for a minimum of four to a maximum of nine to twelve weeks. During this time, their child will be immersed daily in multiple different types of therapies based on initial evaluation by our team. These can include any of the therapies mentioned in this section as well as a selection of the most important biomedical treatments that the team determines should be done, e.g. hard chamber hyperbaric oxygen therapy to augment ATA therapies.

18. **Comprehensive Laboratory Testing**: Our clinic offers the full complement of laboratory tests commonly used for children with autism. It also offers a full spectrum of tests for many of the co-morbid conditions associated with children on the autism spectrum or neurodevelopmental disorders. The tests we order are used to diagnose, treat, and subsequently monitor the patient's care. Not only do I order tests related to the treatment of autism, I also order tests for many other disorders as well as ordering tests for family members when it is in the best interest for the care of their child. With rare exception, the only tests I order are those that affect the treatments I recommend and not be 'curiosity' tests that cost the parents money but add no benefit to the child's treatment plan
19. **Prenatal consultations:** I am frequently asked if I would advise parents how to decrease their risks of having an affected child should they decide to get pregnant again. This is something that I will offer to them as long as they understand that such advice is not intended to replace good medical care from their primary care physicians and obstetricians. Principles of healthy living approached from many different ways are options I can help parents understand so they can make better choices before conception, during, and immediately after.

WHO IS DR. NEUBRANDER?
(As taken from his Position Statement)

Each child that I work with in my practice soon becomes an important part of my "who I am -- why I be". As you will see from my curriculum vitae, I have dedicated years of my life to children, especially children on the autism spectrum. In fact, the total number of calendar years I have worked with these children only tells part of the story because my typical work week is somewhere between 70 to 80 hours. The result of this work schedule has allowed me to evaluate at least twice the number of patients that I would have evaluated in the same number of calendar years if I worked a more normal 40 to 60 hour workweek and therefore has allowed me the opportunity of having seen several thousand children on the autism spectrum over the last fifteen years. I can assure you the more time one spends investigating and studying biomedical treatments in general, and seeing what works and what does not work specifically for any given child, the more one can say, "Yes, biomedical treatments are worth the effort." I can definitely attest to that being what I experience to be true in my practice.

It is *unfortunate* that some biomedical treatments work better than others. It is *unfortunate* what may work for one child may not work for another child. It is *unfortunate* that parents have spent a lot of money chasing biomedical treatments with the hope that they may help when no results were seen. It is *unfortunate* that many doctors order too many tests too soon before observing the results of a treatment, the results of which might have negated having to have ordered some of the tests that were ordered, and something that cost the family money that they would not have needed to spend. It is *unfortunate* that there is no way to predict which child will and which child will not respond to certain therapies.

It is *unfortunate* that pediatricians, neurologists, and other caregivers believe strongly that biomedical therapies are unproven, do not work, and are a waste of money. This is especially *unfortunate* if these same clinicians and caregivers have based their opinions on what the academy for their specialty, e.g. the American Academy of Pediatrics or Neurology, etc., tells them "is true" without them being willing or curious enough to spend the time required to investigate fully the "total body of literature" that does exist in order to form their own conclusions. It is especially *unfortunate* that they have not attended the numerous conferences available where highly intelligent scientists and physicians with impressive curriculum vitas present hard data and compelling arguments for biomedical treatments. It is *unfortunate* that clinicians and caregivers continue to invalidate what parents see and believe to be true. It is *unfortunate* that, after "having dutifully listened" to the parents pour out their hearts, often with a smirk on their face or with a tone in their voice, they tell the parents how sorry they are that they are being duped. It is *unfortunate* that often these same clinicians become angry, raise their voices, and cavalierly dismiss what the parents have just told them as only being "anecdotal", all the while implying that what the parents observed is

nothing more than "seeing what they want to see". It is *unfortunate* that what the parents observe is denigrated and invalidated as unscientific and therefore not real. It is *unfortunate* that conventional medicine only treats with "consensus opinion treatments", often the roots of which lie deep within the soil of pharmaceutical companies, fertilized by the green color of money, and therefore bypasses the wealth of knowledge that has accumulated over the years regarding other "safe treatments" that may help some children.

By contrast, it is *fortunate* that parents can see that all truth has not yet been discovered. It is *fortunate* that parents are not willing to relinquish their powers of observation and the deductions that come from these observations to those who imply they know truth. It is *fortunate* that parents can see through the weaknesses of science and the inconsistencies of clinicians bowing solely to the altar of published studies. It is *fortunate* that parents are intelligent and want the judgment of science with its cold, emotionless facts. It is also *fortunate* that parents demand science's judgment be balanced by mercy – the mercy of hope. It is *fortunate* that this hope in parents never dies, no matter how bleak science may paint the picture or sculpt the clay. It is *fortunate* that parents trust their intuitions and continue to challenge science to look farther, harder, deeper, and longer; to ask new questions; to revisit old paradigms; to find "new truth"; all this for one and only one purpose, to help their children.

Therefore, who am I? **A physician who knows science is always changing and "truth" is always being revised. A physician who knows that convention says that autism is a disorder that is "hard wired" in the brain and therefore it is untreatable. A physician who knows that convention is wrong about this and that at least parts of autism, and parts of the brains of children with autism, are "soft wired" and therefore able to be treated. A physician who trusts what his parents tell him. A physician who then asks questions, the hard questions, after which he follows up by researching what it takes to try to validate what the parents believe to be true. A physician who, by approaching his patients in this manner is finally able to say, "Parents, you were right! And most of all, thank you for teaching me."**

Who else am I? **A physician *dedicated* to keeping an open mind. A physician who continues to *listen*. A physician who *attends* workshops and conferences that are directly related to finding the possibilities of how and why biomedical treatments may work and for what type of child they are best suited. A physician dedicated to *enabling* each parent to investigate safe options that other clinicians may not help them to explore. A physician who will *teach* parents what the laboratory tests are saying about their child. A physician who will *explain* in detail each child's treatment options and then prioritize those options for the parents. A physician who does not require parents to believe as he believes, but who will teach them why he *believes* what he believes and then let them make the final decision whether they want to treat their child as he suggests. A physician who is no longer driven to do every test that may be presented to parents in some book, in some article, or on some chat room, but rather, a physician who *approaches each child as an individual***

and each family's finances as his charge. A physician who attempts to *first use treatments that help the majority* of children in significant ways before ordering tests or prescribing treatments that might be useful for some children, but for the majority of children only produce minimal benefits relative to the costs incurred and the discomfort inflicted upon the child and the family.

And finally ….. **A physician who clearly *has hope,* who unquestionably *gives hope,* and who under no circumstance is willing to steal whatever hope a parent already has, while at the same time a physician seasoned enough to never make promises. A physician who says he *can treat autism, not cure it.* A physician willing to share in a parent's *"possibility thinking". A physician who believes in "maybe" but not in "never".* A physician who understands that *victory is a team effort* and that he is only one member on the team. A physician who knows his limitations and understands that his executive decisions are only as good as the information that parents provide to him. *A physician, therefore, who asks a lot from each parent to accomplish their goal -- his goal -- that goal being to help each child he finds helpless at his door.***

January 1, 2012

Dear Prospective New Patient,

The following set of information you will read in Folders 1 & 2 is intended to help you understand who I am, how I will approach the diagnosis and treatment of your child, and what I will expect from each of you so that I can attempt to meet your goals: "Please help our child yesterday; please use safe treatments; please use effective treatments; and please be conscious not to waste any of our finances by doing research tests, curiosity tests, expensive tests when other lesser expensive tests can give the same information, and/or tests that will not result in better treatments for our child."

It is important for you to understand that I make no promises, nor will I ever. I do not "cure" children; rather I treat them. Should you choose to work with me, I need you to know that our interaction will be a team effort. You can consider me as the general back at Central Command while you are the soldiers out on the frontlines gathering the information I ask you to gather. My executive decisions are only as good as the information you provide to me.

Some parents seek such a relationship while others do not want it. Therefore, to save you from encountering "unfulfilled expectations and misunderstandings", I have provided the following documents for you to study. Once you have read them, hopefully you will know whether or not I am the type of physician you want to work with as you embark on "a road less traveled". This road is a road not traversed by your pediatrician or neurologist. For many reasons, this road is a road you are advised not to take by your doctors, the Institute of Medicine, and by the media. Therefore, should you decide, after studying the materials I make available now and will continue to make available in the future, that you truly want to undertake this adventure and begin this journey with me, then I will be honored to work with you toward accomplishing your goals – my goals also.

If you are investigating whether or not to become a patient of mine, it is important for you to understand the results of my *clinical research for methyl-B_{12}*. Though methyl-B_{12} is only one of the many treatments I offer, I will not force you to give it should you decide against this treatment. However, for most parents it is the one treatment that gives obvious, undeniable results. It provides these changes within a 4 to 6 week period. Overall, when my protocol is followed exactly, methyl-B_{12} is one of the two most powerful treatments I can offer to everyone. I invite you to visit the video section on my website at www.drneubrander.com to learn more about it.

Many of you are seeking me out from all over the country and from all over the world to have me help you with my methyl-B_{12} protocols. However, some of you have never heard of methyl-B_{12}. Therefore, let me say that in my practice, using the protocols that I have developed over the last 9½ years, and after personally evaluating the clinical response to over 1,000,000 methyl-B_{12} injections, methyl-B_{12} shows some type of benefit in 90% of children treated. From this group of children, 90% of the parents report increased executive function, 80% report improvement in speech and language, and 70% report positive changes in emotion and socialization. Side effects include increased levels of activity, the need for less sleep, and mouthing

objects. Approximately 85% of parents that report these side effects in their children refuse to stop the methyl-B_{12} injections because, in their words they say, "We're getting our child back!" It is interesting to note that many children with hyperactivity or sleep problems may improve in these areas after beginning methyl-B_{12} therapy. Most side effects diminish or are eliminated over a three to six month period of time.

My research demonstrates that methyl-B_{12} works far more effectively if given by subcutaneous injections than by any other route of administration. As stated above, the vast majority of parents are extremely fearful and quite hesitant to give their child an injection, something that they initially are to do only once every 3 nights. Most parents do this while their child is asleep, and within a few weeks even the most timid and fearful parents report that giving the shots is the easiest thing they are doing for their child. One of the reasons for this change in attitude is because they realize, from firsthand experience, that the shots don't hurt, and that the process is easy to do. The reason for this is mainly because the shots come in pre-filled syringes. Therefore, they don't have draw up the medication into a syringe. In addition, the process is easy because the procedure uses a local anesthetic cream and is therefore painless. Parents are "afraid of needles". However, the needles are ultra-fine in diameter and therefore do not hurt when entering the skin if a local anesthetic is used and very little if a local anesthetic is not used. The needles are exceptionally short, measuring only 8 mm in length, and when injected into the buttocks at a 10 to 20 degree, the "effective length" of the needle is only 1-2 millimeters – a length too short to do any type of harm whatsoever.

Should you be interested in the science behind the methyl-B_{12} phenomenon, visit the website www.ajcn.org, type in the search field SJ James as the author and myself as one of the coauthors, and obtain the article entitled, "Metabolic biomarkers of increased oxidative stress and impaired methylation capacity in children with autism". Note that it is within the complete article, not within the abstract, that *the heart of the matter is stated in the next to the last paragraph. Here the author states,".... for some children, autism may be a treatable disorder."* Please note that the key word is treat, not cure. My research demonstrates most children can be treated. Never have I used the word cure. As can be observed from Caitlin's video, "the party", or other videos found in the Recovered or Nearly Recovered Kids section on our website, biomedical "treatments" can work very well for many children. However, you will also observe from the videos that the word "cure" is never used by any parent.

The other major treatment that works well when parents follow the protocol I have developed over the last 6 years is hyperbaric oxygen therapy. My basic protocol is quite different than what most clinics do. I believe this is the reason I see the results I see. I believe HBOT, done according to my protocol, is the other most powerful treatment I have to offer. Currently I have monitored approximately 100,000 treatment hours of hyperbaric oxygen therapy with around 800 children on the autism spectrum. I have used low pressure, low oxygen treatments as well as high pressure, 100% oxygen concentration treatments. At this time, it is my strong bias that the combination of methyl-B_{12} and HBOT, when used according to my protocols, are two of the best treatments available to produce language, executive function, and socialization.

If, after reading the above information and after reviewing the videos on my website, you are still interested in considering me to become your doctor, I suggest that you then read the following documents.

1. **Curriculum Vitae – to help you decide if I'm *smart enough* or have *been around the block enough* to care for your child "biomedically".**
2. **List of Services Provided – to help you understand the full scope of what my practice offers, not just what you may think "biomedical treatment" means.**
3. **Position Statement, Initial Office Visit and Consultation Follow-up Procedures, Unique Office Policies, And Fee Schedules -- an important document for you to understand. Here you will "get to know me" – who I am, what I stand for, and what I believe in. It will help you understand how my practice operates so that there are no misunderstandings in the future and so you know the pros and cons of working with me as your physician.**
4. **ASD Initial Office Visit Questionnaire – this is the *typical questionnaire* that you would expect to fill out prior to your initial office visit. You have the option of completing it on your computer or printing it and filling it out by hand. *I prefer that you type if at all possible*.**
5. **Chronological History Form Example – "Jennifer's Story" is *an example of the most important single document* that I need to create a highlights and summary list of how your child is the same as and how your child is different from all other children in my practice that share similar symptoms, events, or diagnoses. I prefer it if parents will use this style when they tell their child's story. This format helps me more quickly capture the highlights of your child's life as they occurred, and it helps me create a more complete Opens List [see below].**
6. **Chronological History Form Template – this is a *template for you to use when presenting your child's case to me.* It is from this form that I will create the highlights and summary list called the Opens List. *I prefer that you type the information if at all possible.***
7. **Supplement Review Program – this is the format you are to use when presenting me a list of your child's supplements. It is found in the download section on my website: www.drneubrander.com (Note: This program is for Windows users only and will not run for MacIntosh users.)**
8. **Checklists for Initial Office Visit and Follow-up Consultations – these documents will remind you what you will be required to bring with you to each type of appointment, whether an initial office visit or a follow-up consultation. *Because they are requirements of the practice, it is important for you to know now what my requirements will be so you can make an informed decision whether or not you will be willing to follow them.***
9. **Directions to the office – the directions to my office are from all the major airports, the train station, and from each direction you may be coming from when you be driving. Because GPSs have trouble finding our 485A Route 1 South address, it is best to type in the address of Bed, Bath, and Beyond which is directly across the street. Their address is 1 Ronson Road, Iselin, NJ 08830. We are the brown building, not the glass building across the road from their business.**
10. **Hotels and Restaurants – Should you decide to become a patient and need information about local hotels or restaurants, you can visit any major**

Internet search engine and type in "Hotels in Edison, Woodbridge, or Iselin, NJ" or "Restaurants in Edison, Woodbridge, or Iselin, NJ". This will provide the latest and most up-to-date information.

After you finish reading the information, I hope you can *feel* from everything I say, and from everything you read in the remaining documents, that I will become totally committed to doing my best, not only for your child, but also for the rest of your family. I hope you come to know that I do what I do because I love it. I did not choose this field of medicine or this specialty of autism. In fact, if the truth were known, I came into it kicking and screaming, much like each of you when you found out your child was autistic. Then something happened – something changed! One day I looked into one of the children's eyes and knew, without a doubt, that he was in there but that he just couldn't find the key to get out. Once I saw this, my attitude changed. I knew that I wanted to unlock his door, have him talk to me, have him tell me how he felt, what his dreams were, and why he was happy or sad. I saw in his eyes the ability to do great things if only the roadblocks were removed. And so, from that first spark of "uh-huh" that started to burn deep within me, I knew then that I couldn't turn back. I knew then that I had to replace my ignorance with as many facts as I could find – "facts" that to me became real, but to many other parents and colleagues, as yet, still remain myths. I find myself where I am today because of you – the parents – my teachers, my instructors. You have taught me to listen and to make my observations without invalidating yours. It is because of you I am.

Sincerely yours,

Jim Neubrander, M.D., F.A.A.E.M.

The complete reference to the scientific article mentioned above:
[now available to read in a PDF file in the download section of my website]
James SJ, Cutler P, Melnyk S, Jernigan S, Janak L, Gaylor DW, Neubrander JA. Metabolic biomarkers of increased oxidative stress and impaired methylation capacity in children with autism. Am. J. Clinical Nutrition, Dec 2004; 80: 1611–1617.

THREE IMPORTANT COMMENTS ABOUT DR. NEUBRANDER AND WHAT HE EXPECTS OF EVERY PARENT WHO WANTS HIM TO TREAT THEIR CHILD

1) FIRST THINGS FIRST FOR ALL FAMILIES WHO HAVE A CHILD ON THE AUTISM SPECTRUM -- THE THINGS WE FACE:

a) WHAT THE FAMILY FACES: To have a child with PDD or autism is a full-time job. It is overwhelming for the family who cannot "get away" to recuperate, have a vacation or even a little time off to rest, relax, and regroup. They work with these children "24/7-365." There is no breathing room. They do not have time to date and rekindle the romance of their relationship. Added to that, the average annual expense for most families to care for a child with autism is $50,000 or more. These expenses are "out-of-pocket" expenses for treatments that are not reimbursed by insurance companies, the state, or the federal government. The divorce rate is over 80%. This most commonly occurs because the mother can no longer work to help supplement the family income and because she is now caring for the child fulltime and taking him or her to this therapy or that therapy. While this is occurring, the father needs to have two and sometimes even three jobs just to make ends meet and pay for everything the family must now pay. By the end of the day the mother has nothing left to give to the father, and the father has nothing left to give the mother (if he's even home and not working at his other job). Without rekindling the romance, only the strongest and most dedicated couples survive.

b) WHAT DOCTOR NEUBRANDER FACES: Autistic spectrum disorders are the most complex of the neurological disorders. There is no "one cause". The diagnosis, and subsequently the treatments, are complex and time consuming. From the Internet, parent groups, and friends, parents hear of other children who have done well and are recovered or who are close to recovery. All parents want the same thing for their child; they want it quickly, and they want to acquire it with the least amount of effort due to the fact that they are already exhausted, overwhelmed, discouraged, and often, openly or hidden below the surface, consciously or subconsciously, very angry. The effort it takes for the doctor to review a child's complex case, with any degree of efficiency to take the "next steps" toward recovery, requires an incredible amount of time if he does his job thoroughly and to the best of his ability. To treat autism is not something that Dr. Neubrander can approach like treating an infection: one bug -- one drug -- fixed! It is not like treating a headache: "Take your aspirin or Motrin and you'll be fine!" Rather, for Dr. Neubrander to effectively treat a child with autism, in the amount of time that is required to do a thorough and comprehensive job, requires more time than either the doctor can dedicate or that the family can pay.

c) THE FAMILY/DR. NEUBRANDER RELATIONSHIP: This can either be a very positive or a very negative experience. The family needs their child to improve. They need "a breather", less work; definitely not more. They need to be able to afford the consultations, tests, and treatments. Dr. Neubrander needs to be able to review everything that worked or didn't work for their child in the past in order to know what to do presently and in the future to help the child. He needs to know this so he will not

repeat things needlessly that shouldn't be repeated, and so he will not repeat unnecessary lab tests that will only increase the cost to the parents while not changing the possible treatment options he will recommend. Dr. Neubrander needs to have all the information at his fingertips so he does not have to attempt to find the necessary information in the child's chart that is already large, if not huge. For him to have to search for any information from the chart takes time, and results in potential oversights, incompleteness, and errors because the time allotted for the follow-up appointment is too little for him to be the one trying to recreate the child's case. Dr. Neubrander is rendered less effective, and sometimes totally ineffective, when parents do not present to him the appropriate follow-up forms and the supplement review program updated and thoughtfully reviewed. Parents who do not understand this frequently present nothing and say, "We're only reviewing labs today." What they don't understand is that the labs ordered are interrelated to the child's past and present history, current symptoms, medications currently being taken, medications taken in the past successfully or unsuccessfully, supplements being consumed or not consumed currently or in the past, past lab tests of all types, whether the parents understand how they are related or not related to the current tests being evaluated that day, and all the treatments or therapies the child is currently receiving which the results of the test may affect. Other parents who do not understand the process frequently say, "You have his supplement review program from before. Nothing has changed." What they don't understand is that the total combination of things has changed because it is rare that they have not added or subtracted at least something from their child's supplement schedule. When that happens, it is very ineffective and incomplete and time consuming for Dr. Neubrander to have to alter the previous supplement form. What he has learned is that those who do not complete the Supplement Review Program are the ones who have the most "holes" in their child's program, though they are the group who believe the strongest that "we are taking everything Dr. Neubrander suggests." Based on thousands of reports, that being the case is very rare.

d) TO BE CONSIDERED BY THE FAMILY AND THE DOCTOR IF THERE IS A PROBLEM WITH THE "DOCTOR/PATIENT" COMBINATION: The word doctor means "teacher". Because there is so much for families to learn if they are going to see the greatest positive effects from biomedical treatments for their child, and because there is limited time on the doctor's part and limited financial resources on the parents part to hire the doctor to spend hours teaching and tutoring them, the doctor has created the comments and materials he needs all patients to first read, then re-read, and finally study. Informed parents see things that they would not otherwise have seen. They are able to see the hidden or camouflaged clues that they would have missed if they did not study the information given. They are now prepared to ask better questions, obtain better answers, and act upon these answers to move their child forward, faster, more effectively, and in a better way than would have happened if they just "saw the doctor" one more time. When families thoughtfully, thoroughly, and correctly complete the Comprehensive General Follow-up Form, the Parent Designed Report Forms (only when required which varies with the type of appointment being scheduled), and the Supplement Review Form, the doctor is able to MULTIPLY THE BENEFIT of each consultation by several fold rather than having it divided many times as he wastes time in a feeble attempt to gather the information he should already have at his fingertips when the consultation begins. When

the doctor has all the information at his fingertips at each consultation, he can immediately review the child's entire past in order to effectively alter the child's current state and subsequently his or her future progress. Without it, what is accomplished is at best anyone's guess. Parents feel unfulfilled and as if the appointment was a waste of their time and money. The doctor feels frustrated knowing that he could have helped the child by adding several things to the child's diagnostic or treatment program but was blocked by the unpreparedness of the parents. Therefore, if the type of practice that Dr. Neubrander has designed, and found to be successful for those who do it, is too difficult for the parents to do, then it is best that the parents work with another doctor who has fewer requirements. This is better for both parties involved, the doctor and the patient, because the frustration levels that will be experienced by all will no longer exist.

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2) WHAT IS YOUR CHILD WORTH?

Unfortunately, "Dr. Neubrander's Paperwork" is often not understood by parents just starting to be seen by his practice, and therefore parents will "wash out and quit" thinking the paperwork will always be this hard before they ever get to the easy part. That is why this comment was written.

Is your child worth **averaging two minutes of paperwork per day** for the first six months and from that point forward **averaging 20 seconds per day**? Your obvious answer is, "Yes, undoubtedly so!" Therefore, to let you see what will be happening over the next 6 to 12 months, consider the following time sequence as it applies to most patients:

Paperwork presented at the Initial Office Visit was completed prior to the Initial Office Visit: Range of time to complete the paperwork is 6 to 20 hours with an average of 10 hours. The first follow-up consultation following the Initial Office Visit should occur 6 weeks later.

First follow-up consultation: Range of time to complete the paperwork is 1.5 to 2.5 hours (if typed and setup to be a template for future appointments by using the 'Save As' function). The next follow-up should occur 6 weeks later.

Second follow-up consultation: Range of time to complete the paperwork is 1.75 to 2.5 hours (if typed and setup to be a template for future appointments by using the 'Save As' function). The next follow-up should occur 6 to 8 weeks later.

Third follow-up consultation: Range of time to complete the paperwork is 0.75 to 1 hour (if typed and setup to be a template for future appointments by using the 'Save As' function). The next follow-up should occur 6 to 8 weeks later.

Fourth follow-up consultation and beyond: Range of time to complete the paperwork is 10 to 20 minutes (if typed and setup to be a template for future appointments by using the

'Save As' function). The next follow-up should occur 6 to 16 weeks later depending on what diagnostic procedures are being interpreted and/or what treatments are being recommended.

Once a person is established into the practice, has entered the basic data onto the appropriate forms, and the optimum frequency for the methyl-B12 shots has been established (usually after the 3rd consultation), the average amount of time it takes for a parent to complete the required paperwork is only 10 to 20 minutes. The paperwork is a requirement that occurs for each appointment whose occurrence averages, for most patients, once every 6 to 12 weeks initially, and once every 12 to 16 weeks after being in the practice for 6 to 12 months. Therefore, the much maligned talk about Dr. Neubrander's paperwork is mythical, not factual! In fact, when patients stay on target, by the 6th month with Dr. Neubrander, they will have implemented many of the major treatments steps and will have only spent 6 hours doing it. THAT AVERAGES ONLY 1 HOUR PER MONTH WORTH OF PAPERWORK FOR THE FIRST 6 MONTHS WHICH EQUALS 2 MINUTES PER DAY! FROM THAT POINT FORWARD, THE PAPERWORK AVERAGES 10 MINUTES PER MONTH WHICH AMOUNTS TO 20 SECONDS PER DAY!

The problem is not that the paperwork is too hard or takes too much time; rather the problem is that parents do not type it so that in the future they only have to update the changes rather than starting all over or that they delay doing it until the last minute before an appointment and then rush through it, frustrated, and subsequently not taking their time to do it thoroughly and as thoughtfully as possible. When done in this manner, it definitely affects, to the negative, how well the doctor can care for the child. If treating autism was simple, every doctor would be able to get results. It is not simple and everything about the child's past history, positive and negative laboratory tests, treatment successes and treatment failures reflect upon what the doctor needs to do at each subsequent appointment as he reviews the latest information and updates medications, treatments, or diagnostic tests. To review all the pertinent features that will potentially add to the patient's success is very time consuming process and to do it comprehensively, and as inexpensively as possible can only occur if everything is at the treating doctor's fingertips during the appointment time.

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3) WINNING THE SUPER BOWL!

(The take home message is that our chances of doing a lot for your child are excellent as long as we have taught you how to play the game and play it according to the rules and playbook)

Bill Belichick, coach of the New England Patriots that won three Super Bowls in four years and had a perfect 16-0 record, is a nice guy -- off the field. However, on the field and in the locker room he has a job to do -- prepare to win. To do that he is seen at times as ruthless, cruel, uncaring, and a tyrant. However, he wins! The same can be said of

Vince Lombardi, Bill Parcels, Mike Ditka, Bill Cower, and the list goes on and on. However, the bottom line is that each of them won!

Is this how they did it? Is this what they all said on Day One of pre-season summer training camp every July and August. "OK guys, listen up. It's great to have the old-timers back again this year as well as those of you who have not played with our team before as well as you rookies. Anyhow, this is how we're going to do things around here this year so we can win the Super Bowl. First off, here's your play book. Read it if you like. There's probably no real need to study it because by the time you've gotten to this level in your careers, you pretty much know about football. Besides that, it would take a lot of time to go through it and learn everything and I know you are all quite busy being famous and all. Now, about practice. You know how hot it's been this summer. Therefore, I wouldn't want any of you to have a heat stroke so you don't have to run and get all sweaty and stuff until it's cooler later on in the season. Should it rain, the ground could get all muddy and slippery and if you ran and practiced cutting back and forth, you might slip and fall and sprain something. That wouldn't be good for the team, you know, having you on injured reserve. The team needs you to not be hurt. Which brings up another thing. When it's cold outside, you don't have to practice either because you might get chilled and catch yourself a cold which could also put you out of the game. Once again, you wouldn't be much good to the team if you were sick and all. OK guys, now that you know how it's gonna be this year, let's all put our hands together and give our cheer for the next Super Bowl Champs! Go Team Go!"

So it is with Dr. Neubrander! He's first and foremost your coach. If you knew how to play the game and get your child well, you would have already done it by now. If all your other doctors were good coaches, they would have already won the game with you. Coaches are not known for being nice guys. Coaches are known for taking their players to the next level and beyond, helping them reach their fullest potential, and at times, even go beyond. Coaches can be nice. Coaches are nice. However, the job of a coach is not to pass out cookies and hot chocolate, to coddle and soothe, and to say to his players, "That's OK, I know how tired you must be having had to run all those laps out there. And I know you must be having a really bad day with all those bruises you got in practice. And I also know your muscles must be very sore and aching like a toothache. So, go ahead. Take it easy for a few days. Don't strain yourself. What's important to me is for you to know how much I care about you and how sorry I am that you have to endure all the hard things you have to endure out there on the practice field. Don't worry about practice anymore. And don't worry about reading and studying your play book, especially when you have had such long days and come home and just want to crash on the couch and fall asleep. It really doesn't matter all that much as long as you just be sure to show up for the games."

Absurd! Bizarre! Crazy! Ridiculous! RIGHT. And so it is to think that you can win this game for your child without learning your play book. In order to learn it, you can't just scan it. Nor can you just read it. You have to study it!

Think of Dr. Neubrander as the following eight things.

1) He's a ***Coach***. A coach leads the team. He designs the plays. He directs. He demands. He pushes. He's tough. He commands respect and receives respect, not necessarily love. He likes to be loved but doesn't need it. He needs excellence; he expects excellence; nothing less. He will not accept excuses. He's driven to win. He hates to lose. And in the end, win or lose, his team is better than what it would have been without him. This is who Coach Neubrander is for himself and for your child.

2) He's a ***Computer***. A computer gives back information proportional to what is put into it. Therefore, the more thoughtfully and comprehensively you fill out your Comprehensive General Follow-up Forms and Supplement Review Forms, the more information Computer Neubrander can provide for you.

3) He's a ***Search Engine***. A search engine is only good if the right questions are asked. Therefore, the more thoughtfully and comprehensively you fill out your Comprehensive General Follow-up Forms, the more Search Engine Neubrander will be able to see what questions you have, whether or not you ask them in the Questions Section. In addition, Search Engine Neubrander will be able to ask many more questions for you that you should have asked but didn't even know to ask. The ability for him to do this is directly proportional to how thoughtfully and comprehensively you fill out your Comprehensive General Follow-up Forms, especially the Questions Section.

4) He's the ***Rules of the Game***. Without knowing the rules of the game, there is no way to play, much less win. The handouts and comments that Rules of the Game Neubrander gives to you will let you know when it's your turn, what pieces to move, when to move them, and where they go. Key handouts and comments or comment sets will let you know how to correctly provide the information needed to play the game correctly, and what you should and should not do in order to have the best chance of winning. By carefully studying the rules of the game, there is no guarantee that you will win, but you will definitely be able to play the game.

5 & 6) He's the ***Play Book and the Quarterback***. Without knowing the plays of the game that Play Book Neubrander uses, you will be running one way while Quarterback Neubrander is expecting you to be going the other way in order to catch the ball that he just threw to you. Without knowing the plays of the game, there is no way for you to be in the right place at the right time in order to score and eventually win the game because the passes that Quarterback Neubrander throws your way will either hit the ground because you were not there to catch the ball, or the ball will be intercepted by players on Team Autism who will then progress towards their goal, all the while taking you further away from yours.

7) He's a ***General in the Army.*** A general needs his troops to know all about the enemy and the terrain and the obstacles so that he can direct them. General Neubrander needs his troops to study everything about the enemy and the terrain wherein they hide as well as all the obstacles that they may face when they confront the enemy. Therefore, the more thoughtfully and comprehensively you fill out your Comprehensive General

Follow-up Forms and Supplement Review Forms, the more General Neubrander will be able to see what dangers you will face or are already facing. General Neubrander will also see what you still need to learn and study about the enemy so that you are not lost in battle or ambushed along the way.

8) He's a ***Master Chef***. A master chef orchestrates the timing of exquisite meals. A master chef knows when to start something cooking or baking so that it will still be ready to be added to the next thing at just the right time so that the meal comes out as it should -- appetizers before entrees before desserts. Master Chef Neubrander knows what tests need to be coordinated and precede what other tests so that one doesn't end up being served their dessert at the beginning of their meal and their appetizers at the end of their meal. Master Chef Neubrander knows what is on his menu, the signout sheet that parents receive from his Autism Restaurant. He knows that for him to present them with a beautiful meal that they will always remember, they need to eat their appetizers before their desserts. To do this so their child's autism treatment is effective and done in the right order and not delayed, they need to obtain the tests immediately that Master Chef Neubrander has ordered.

Hopefully you will work towards winning the Super Bowl with Dr. Neubrander and his team. Together we can go farther than we ever would have if we found ourselves alone!

Updated January 1, 2012

Position Statement, Initial Office Visit and Consultation Follow-up Procedures, Unique Office Policies, and Fee Schedule Principles

Each child that I work with in my practice soon becomes an important part of my "who I am -- why I be". As you will see from my curriculum vitae, I have dedicated years of my life to children, especially children on the autism spectrum. In fact, the total number of calendar years I have worked with these children only tells part of the story because my typical work week is somewhere between 70 to 80 hours. The result of this work schedule has allowed me to evaluate at least twice the number of patients that I would have evaluated in the same number of calendar years if I worked a more normal 40 to 60 hour workweek and therefore has allowed me the opportunity of having seen several thousand children on the autism spectrum over the last fifteen years. I can assure you the more time one spends investigating and studying biomedical treatments in general, and seeing what works and what does not work specifically for any given child, the more one can say, "Yes, biomedical treatments are worth the effort." I can definitely attest to that being what I experience to be true in my practice.

It is *unfortunate* that some biomedical treatments work better than others. It is *unfortunate* what may work for one child may not work for another child. It is *unfortunate* that parents have spent a lot of money chasing biomedical treatments with the hope that they may help when no results were seen. It is *unfortunate* that many doctors order too many tests too soon before observing the results of a treatment, the results of which might have negated having to have ordered some of the tests that were ordered, and something that cost the family money that they would not have needed to spend. It is *unfortunate* that there is no way to predict which child will and which child will not respond to certain therapies.

It is *unfortunate* that pediatricians, neurologists, and other caregivers believe strongly that biomedical therapies are unproven, do not work, and are a waste of money. This is especially *unfortunate* if these same clinicians and caregivers have based their opinions on what the academy for their specialty, e.g. the American Academy of Pediatrics or Neurology, etc., tells them "is true" without them being willing or curious enough to spend the time required to investigate fully the "total body of literature" that does exist in order to form their own conclusions. It is especially *unfortunate* that they have not attended the numerous conferences available where highly intelligent scientists and physicians with impressive curriculum vitas present hard data and compelling arguments for biomedical treatments. It is *unfortunate* that clinicians and caregivers continue to invalidate what parents see and believe to be true. It is *unfortunate* that, after "having dutifully listened" to the parents pour out their hearts, often with a smirk on their face or with a tone in their voice, they tell the parents how sorry they are that they are being duped. It is *unfortunate* that often these same clinicians become angry, raise their voices, and cavalierly dismiss what the parents have just told them as only being "anecdotal", all the while implying that what the parents observed is nothing more than "seeing what they want to see". It is *unfortunate* that what the parents observe is denigrated and invalidated as unscientific and therefore not real. It is *unfortunate* that conventional medicine only treats with "consensus opinion treatments", often the roots of which lie deep within the soil of pharmaceutical companies, fertilized by the green color of money, and therefore bypasses the wealth of knowledge that has accumulated over the years regarding other "safe treatments" that may help some children.

By contrast, it is *fortunate* that parents can see that all truth has not yet been discovered. It is *fortunate* that parents are not willing to relinquish their powers of observation and the deductions that come from these observations to those who imply they know truth. It is *fortunate* that parents can see through the weaknesses of science and the inconsistencies of clinicians bowing solely to the altar of published studies. It is *fortunate* that parents are

intelligent and want the judgment of science with its cold, emotionless facts. It is also *fortunate* that parents demand science's judgment be balanced by mercy – the mercy of hope. It is *fortunate* that this hope in parents never dies, no matter how bleak science may paint the picture or sculpt the clay. It is *fortunate* that parents trust their intuitions and continue to challenge science to look farther, harder, deeper, and longer; to ask new questions; to revisit old paradigms; to find "new truth"; all this for one and only one purpose, to help their children.

Therefore, who am I? **A physician who knows science is always changing and "truth" is always being revised. A physician who knows that convention says that autism is a disorder that is "hard wired" in the brain and therefore it is untreatable. A physician who knows that convention is wrong about this and that at least parts of autism, and parts of the brains of children with autism, are "soft wired" and therefore able to be treated. A physician who trusts what his parents tell him. A physician who then asks questions, the hard questions, after which he follows up by researching what it takes to try to validate what the parents believe to be true. A physician who, by approaching his patients in this manner is finally able to say, "Parents, you were right! And most of all, thank you for teaching me."**

Who else am I? **A physician *dedicated* to keeping an open mind. A physician who continues to *listen*. A physician who *attends* workshops and conferences that are directly related to finding the possibilities of how and why biomedical treatments may work and for what type of child they are best suited. A physician dedicated to *enabling* each parent to investigate safe options that other clinicians may not help them to explore. A physician who will *teach* parents what the laboratory tests are saying about their child. A physician who will *explain* in detail each child's treatment options and then prioritize those options for the parents. A physician who does not require parents to believe as he believes, but who will teach them why he *believes* what he believes and then let them make the final decision whether they want to treat their child as he suggests. A physician who is no longer driven to do every test that may be presented to parents in some book, in some article, or on some chat room, but rather, a physician who *approaches each child as an individual* and each family's finances as his charge. A physician who attempts to *first use treatments that help the majority* of children in significant ways before ordering tests or prescribing treatments that might be useful for some children, but for the majority of children only produce minimal benefits relative to the costs incurred and the discomfort inflicted upon the child and the family.**

And finally ….. **A physician who clearly *has hope*, who unquestionably *gives hope*, and who under no circumstance is willing to steal whatever hope a parent already has, while at the same time a physician seasoned enough to never make promises. A physician who says he *can treat autism, not cure it.* A physician willing to share in a parent's "*possibility thinking*". *A physician who believes in "maybe" but not in "never".* A physician who understands that *victory is a team effort* and that he is only one member on the team. A physician who knows his limitations and understands that his executive decisions are only as good as the information that parents provide to him. *A physician, therefore, who asks a lot from each parent to accomplish their goal -- his goal -- that goal being to help each child he finds helpless at his door.***

VERY IMPORTANT – TO AVOID MISUNDERSTANDINGS AND DISAPPOINTMENT, PLEASE UNDERSTAND THE SECTION THAT FOLLOWS

REGARDING YOUR INITIAL OFFICE VISIT

(Wherever the word doctor is used, you may substitute by saying Physician Assistant or Professional Staff.)

"Making The Most Of Our Time Together" **Unlike initial office visits you might have had with other doctors in the past, the initial office visit with Dr. Neubrander will be different in many ways. Probably the most obvious way is that the doctor will be studying the information you present to him rather than spending much time talking to you in the typical "back and forth question and answer session" that usually occurs the first time you meet with a doctor. In order for the doctor to most effectively "set the stage" to help you reach your number one goal – "help my child" – he will be requiring that you do your homework and present to him the things he asks for in detail, without being tempted to take short cuts, something that will definitely limit him in what he can figure out about your child.**

******The initial office visit will proceed as follows***:***

You will present to the doctor the information described below. He will then complete a physical exam. Because your initial office visit was prepaid in full, once the doctor completes the physical exam, tells you anything that he may want to tell you, and answers a few basic questions, you will return home. Once you leave, the doctor will immediately order any medications he will want your child to begin taking, e.g. the methyl-B_{12} prefilled syringes and numbing cream. The doctor will then study the detailed "homework pages" that took you hours to prepare. He will use this information to create the Opens List. ***The Opens List is an important document he will use for future consultations to quickly and comprehensively review your child's complete case.*** **The Opens List allows him to differentiate how your child is the same or different from all the other children he has seen who carry the same diagnosis. From this initial set of information, he will create a plan of action for your child.**

In general, when you leave the office after your initial visit, you will receive no billing information. This will follow a few weeks later by mail or email in what we call a "signout packet". The signout packet contains everything you need: a) a coded Superbill to submit to your insurance company; b) a copy of the Opens List; c) a copy of the physical exam; d) a copy of the remainder of "the signout" itself that was not presented at the Initial Office Visit.

The signout itself shows all the medications ordered. It shows all the laboratory tests recommended by the doctor and the cost of each test (when known). It includes all laboratory prescriptions that will need to be presented to laboratory personnel in order to complete the tests. The signout will indicate the names of the labs doing any "specialty tests" not available from the common commercial labs like Quest or LabCorp. The signout will let you know if you need to expect a special kit from one of these specialty labs if such a test was ordered. The signout will show when to schedule your first follow-up appointment and what to tell my staff when scheduling the appointment.

In addition, the signout will include many pages of comments and/or handouts/emails that are informative, or will tell you the web address where you can find this information. These handouts/emails/websites teach the concepts and principles necessary to understand biomedical treatments, and my specific way of using them. These handouts/emails/websites indicate the procedures required by my practice so I can effectively treat your child as quickly as possible in order to maximize his or her potential. Though optional to be given at the initial office visit, often the doctor makes these handouts/emails/websites available when

you see him for the first time. This allows you to start the learning process before you receive all the other information that will follow in the complete signout packet.

Because the doctor will immediately order methyl-B_{12} and the numbing cream after completing the physical exam, the "compounding pharmacy" will be calling you the next business day after your appointment to finalize shipping instructions and the method of payment you want to use. (See the Keys for Success document for more detailed information)

The doctor is sorry that the Initial Office Visit will not be an office visit for you to get your questions answered. However, he wants to reassure you that all your questions will be addressed at each of your follow-up visit, especially if you ask them in the Questions Section at the end of the Comprehensive General Follow-up Form. Hopefully, from the description below, you will see why this process, that he has developed and refined over the last 15 years, is one that will ultimately give you more answers than the customary back-and-forth, eyeball-to-eyeball, question and answer interview session that occurs with other doctors and their staff.

What is due at the Initial Office Visit:

First*, you will present to the doctor *the Two Non-Optional Items*: 1) Chronological history (in the format requested); 2) The Autistic Spectrum Disorder Initial Office Visit History Questionnaire completed in detail including a dietary history for the last 9 days. *Second*, you will *present* to the doctor *copies* of as many of the *Optional Items* that you can obtain prior to the initial office visit: 1) Laboratory results, especially within the last 2 years; 2) Other types of documentation diagnosing and/or evaluating your child. The doctor will then take the information presented and review its contents in order to know how much or how little has been done as it relates to what he will be doing. In your absence, he will then begin "the major portion of his work". He will study your child's case to accomplish as much as possible from the first office visit. He will determine what path or paths are most likely the ones that will give him the most information to begin the subsequent diagnostic, testing, and treatment procedures. *It is important to understand that this is the only office visit that will be primarily designed for him to get the answers he needs to begin the quickest and most cost effective way to help your child. All other office visits are designed for you to get the answers to your questions as long as you complete the required Comprehensive General Follow-up Form. In this form, there is an entire section for you to ask all the questions for which you want answers.

What the doctor does after you leave to return home:

As stated above, following your Initial Office Visit, in your absence the first thing the doctor will do is review in detail the Chronological History Form – your child's story-- and mark all over its pages with red pen to highlight the many ways your child is the same and the many ways your child is different from other children who have similar symptoms, problems, and/or diagnoses. Next he will review the ASD Initial Office Visit History Questionnaire along with all pertinent lab data you have provided *[please make copies before you come; there is no one at the office who will have time to do this for you].* Then the doctor will review the findings of the physical examination that was performed paying special attention to the physical signs frequently seen in children on the autistic spectrum. Once he has completed each of these functions, he will then create what he calls an "*Opens List*". This list is a *Summary Of Key Points* in your child's case that the doctor will want to be able to review at all future appointments *"at a glance"* so he can quickly remember the highlights he has gleaned from your Initial Office Visit. Once the creation of the Opens List is finished, the doctor will complete the session by filling out any uncompleted portion of what is called the "Sign-out Sheet". As described above, in this Sign-out Sheet will be a list of all prescriptions for medications and lab tests, instructions about obtaining laboratory specimens correctly, the "next steps" you are to make to begin the treatments being suggested, your "next steps"

for rescheduling your follow-up appointments, pertinent comments relating specifically to your child and comments about the treatment(s) being implemented, how to obtain additional information that more thoroughly explains the science and rationale under girding the biomedical approaches the doctor uses, a copy of the Physical Exam, and a Superbill to submit to your insurance company.

Hopefully you now understand why our initial office visit works the way it does. As you can see, for the doctor to answer the numerous questions most parents have, to explain what parents want to know about medications, treatments, laboratory tests, procedures, "why did this happen to our child", etc., to complete the physical exam, and still achieve his primary goal, within the one and one-half hour time allotment, would be impossible. By now you know that the primary goal for the initial office visit is to create the most comprehensive diagnostic and treatment plan possible.

The doctor would appreciate anyone who sees him to already be well past the "this is a football" set of basics. This includes any information about who he is, what he does, and why he does what he does. If you need to learn about the types of things he does, he recommends that you read *Children with Starving Brains* by Dr. Jaquelyn McCandless and *Healing the New Childhood Epidemics* by Dr. Ken Bock. If you have not seen the videos on our website, we suggest you visit www.drneubrander.com and watch several of the videos from different categories. It is important that you have an understanding that the success Dr. Neubrander sees is relative to where a child was before treatment when compared to how the child is found to be following a treatment. Some children progress very much and come off the spectrum. Others remain severely autistic but, due to our treatments, are able to achieve a much better "quality of life". These benefits are not only valuable for the affected child, but are benefits that are also realized by the entire family.

REGARDING YOUR FOLLOW-UP CONSULTATIONS

At the initial office visit, the doctor will emphasize the importance of the Checklist items he wants you to present to him for each future follow-up meeting. These will be indicated in the Keys for Success document and will also be provided to you by the administrative staff as a reminder in your confirmation information that you will receive when you schedule your follow-up appointment. The more comprehensively you do this prior to each consultation, the more clinically effective and the more cost effectively the doctor can treat your child. This is also the best way to keep your costs down. It requires less time by the doctor to get the same amount of information. And, especially in this case, as the saying goes, "Time truly is money."

The doctor has treated autism since the early 90's. He has completed thousands of interviews with parents whose children suffer from autism. He now sees children on the autism spectrum almost exclusively. Over the years, by trial and error seeing what works and what doesn't work, he has learned that *he can only perform at his highest level when parents take enough time to provide all the details he asks them to provide.* He is famous for making parents feel like they are back in school. He has frequently been referred to as being harder and more demanding than a parent's strictest professor ever was. He is known for saying, "No book report or term paper ever written in the past is more important than the Comprehensive General Follow-up Form and Parent Designed Report forms you should be writing for me. These are the tools I need at my fingertips in order to apply everything I know to help your child reach his or her maximum potential!" The reason Dr. Neubrander requests the "homework" he does is to accomplish what every parent wants: "Please fix our child as soon as possible. Please use safe treatments. Please use effective treatments. Please order the fewest number of tests possible, and only order those tests that will make a difference in what you will use to treat our child. This way we will not spend more money than we have to spend." The only way to comprehensively do this is to have every bit of

information immediately available at every consultation. Because you are paying for the doctor's time, the more information he already has from you, the less time he will have to waste asking you questions and writing your answers down in the chart. Either you do it or he does it. One way is more expensive while the other way is less expensive. One way is more comprehensive while the other way is less comprehensive. One way provides many results while the other way provides few, if any results. Therefore, to complete all the paperwork ahead of time before it is required is the best answer for everyone -- the patient; the parents; the doctor. As every parent knows, this disorder is complex. It is time consuming, and an easy answer to fixing it does not exist. *The paperwork, properly completed, allows the doctor to review your child's ENTIRE CASE in 15 minutes or less.* Once reviewed, the rest of the appointment can then be used for the doctor to make "executive decisions" to design the next set of treatments. It can also be used to determine whether further testing may speed up the healing process for the child.

Because parents are already overwhelmed by the everyday responsibilities necessary to care for their special needs child, the last thing they need is more work! Often they resent the paperwork until they understand why it not only helps the doctor, but how it also helps them follow their child's progress better, and at the same time allows them to be charged less because they use less of the doctor's time.

Frequently parents say, "There's been no change since the last consultation so why should I have to complete the paperwork?" The reason is because every consultation is most accurate when it "stands alone and is complete unto itself". When completed this way, in the future, when any one of the professional staff members needs to review the child's chart, they will be able to recreate what the child was doing on any given date. When a question arises, unless the doctor is able to recreate what happened at any of the past appointments, though he will be able to give *an answer*, he will be unable to give *the best answer.*

OTHER POLICIES THAT MAY BE UNIQUE

Parents may find to following policies be unique to Dr. Neubrander's practice. They include:

1. A non-refundable scheduling fee just to hold the initial appointment slot once the parents have made the appointment "firm".
2. A strict cancellation policy.
3. A strict rescheduling policy.
4. A strict policy for no shows.
5. A current and valid "on file" credit card policy used for prepayment of the initial office visit, for phone consultations, and for payment of missed appointments.
6. A general office policy refusing to write letters of medical necessity for issues that are repeatedly rejected by insurance companies. (Note, however, that the doctor may occasionally write a letter he feels strongly "may have a chance". When written, such a letter will be billed at his hourly rate and charged to the family.)
7. Letters to attorneys will be charged at the doctor's hourly rate. A retainer fee for the estimated time it will take the doctor to write the letter must be paid in advance by the attorney's office or by the patient's family. Adjustments and credits owed will be made when necessary.
8. A retainer fee for the estimated costs required to process and send medical records to an attorney's office must be paid in advance by the attorney or the patient's family.
9. Legal cases will not be accepted.
10. Cases involving parental jurisdictional issues, where both parents do not agree in writing that they want Dr. Neubrander or his PA to treat their child using the biomedical approaches they use, will not be accepted into the practice.
11. Medicaid and Medicare patients cannot be accepted as patients unless they agree to be seen outside the system on a "private pay" arrangement. If they choose to be seen, they will

need to sign an agreement stating they will not submit claims to Medicare or Medicaid and that they understand they are responsible for all payments at the time of service.

The doctor knows these office policies are not usual and customary. It is never his desire to not be understanding and help parents who are already struggling, both emotionally and financially. However, there are definite reasons the policies shown must be in place. There is "no free time" in the doctor's appointment book. When a person cancels or wants to reschedule an appointment without adequate lead-time so the office can refill the appointment slot, some other child that could have used that appointment time to be treated will not be able to be helped. In addition, there are financial consequences that should be the patient's responsibility, not the doctor's responsibility, to bear. Because the type of practice the doctor has does not involve "acute care", and because it is a practice that is "voluntary" on a patient's part, it is best to think of the scheduling, cancellation, and no show policies similar to buying a ticket to go to a Broadway play and then not going – the theater has "sold the seat to you" when it could have sold the seat to another person. If you do not show up, the theater will not refund the price of the ticket because it cannot resell the seat. Therefore, experience has taught us that "when money is on the line" there are fewer missed, cancelled, or rescheduled appointments unless a true emergency exists.

In addition to everything stated above, it is important to understand that Dr. Neubrander orders diagnostic tests from specialty laboratories, and uses numerous biomedical treatments, most of which do not qualify for insurance reimbursement. The reason this is so is because insurance companies are only responsible to pay for things that are "standard of practice". In general, insurance companies do not enter into a debate whether or not something has scientific basis to be tried or not tried. Rather, insurance companies take the position that there are not enough studies to warrant a consensus opinion among conventional medical practitioners for the treatment or testing Dr. Neubrander is doing. Because of this, insurance companies consider what Dr. Neubrander is doing to not be "usual and customary". They consider such diagnostic tests and clinical treatments as "experimental" and they are not responsible to pay for "experimental procedures". Most insurance companies, after rejecting a claim that is later challenged by a patient, will respond by asking for a letter of medical necessity from the doctor. Over the years, it has been Dr. Neubrander's experience, for the type of practice he is involved in, that more than 90% of such letters of medical necessity are rejected for the reasons just described. With that fact in mind, parents wishing Dr. Neubrander to treat write such a letter will most often be refused. If the parents still want to have him write such a letter, they will be required to sign an informed consent indicating they have been fully informed that there is little chance that the doctor's letter will help them get insurance reimbursement, and that they understand they will be charged for the time it takes for him to write the letter.

Fee Schedule for Dr. Neubrander's Practice
Last Updated January 1, 2010

Fee Schedule for the Doctor

General Information for patients from the US

a) Initial Office Visit, Basic: $750 [not based on time spent in consultation].
b) Follow-up visits and phone consultations: Based on a $400/hour fee schedule.
c) Phone consultations are based on actual time spent on the phone *plus* the additional time it takes for the doctor to finish completing the Sign-out.
d) Office visits are scheduled with a minimum 30-minute time slot and then additional time allotments in 15-minute increments.
e) "Initial Office Visits plus First Follow-up" combined visits: The cost is based on the total time required by the doctor billed at the $400 per hour rate. The final cost is based on the time required to complete the physical exam, and the complexity of the case. The complexity of the case will affect the total amount of time the doctor needs to review the case and create the Opens List prior to the consultation, and the total amount of face-to-face time that is needed during the consultation itself. The total amount of time that is customarily required for most patients doing a "combined consult" averages between 3 to 5 hours.

Miscellaneous Information

a) Phone calls received for cancellations or for rescheduling are documented by a time stamp by our phone system. If you call and reschedule directly with a staff member, an email confirmation will be sent to you documenting the time of the call. If you cancel by voice mail or email, the date and time will be documented from the time stamp by answering machine or email. If you ask to reschedule for a certain date by voice mail or email, the date and time will also be documented from the time stamp by answering machine or email.
b) Scheduled appointments are best "guess-timates" for the amount of time needed for simple and routine cases for the type of consultation it was anticipated to be. However, if the appointment cannot be completed within the scheduled time, for whatever reason, including additional questions and concerns that the parents want answered, the doctor will either...

i. End the consultation before it is finished and have the patient reschedule additional time in order to complete the unfinished portion of the appointment.
ii. Spend the entire allotted time reviewing lab data, explaining treatment options, etc., and complete the write-up portion of the signout at a later time.

c) Cases that turn out to be complex or that need more time to complete, for whatever reason, will be billed at the customary physician rate for the extra time that is needed to complete the write-up process at a later point in time.
d) The amount of time it takes to do the write-up to complete the signout varies greatly. The amount of time required is directly related to the complexity of the case and how much the doctor must do to finish the job with excellence. There is no way to predict what this will be ahead of time so the doctor and PA cannot agree to finish within a certain amount of time due to financial reasons by the parents.

Definitions to Clarify Our Position so There is No Misunderstanding

Definitions:
a) 0:00 hours to 24 hours is what is referred to as less than 24 hours.
b) 24 hours and 1 minute to 48 hours is what is referred to as 24 to 48 hours.
c) 48 hours and 1 minute to 72 hours is what is referred to as 48 to 72 hours.
d) A 7-day advance notice is 7 full calendar days.

Credit Cards and Billing:
a) Credit cards are now accepted for all services.
b) Payment is due at time of service. Billing never occurs, either to patients or to insurance companies.

Medicare and Medicaid:
a) The doctor is not a Medicare Provider and therefore does not keep a UPIN number.
b) The doctor does not treat Medicare or Medicaid patients unless done outside of the system as a "private pay" arrangement.

No shows, cancellations, and rescheduling:
a) All appointments missed will be billed as a "no show" on the day of the no show. Only severe weather and true family or medical *emergencies* will be accepted as reasons not to keep an appointment. Documentation of the emergency will be required to have the no show charge credited to your account. We do not like having to do this. However, too many patients have abused the system by calling and saying they have "an emergency." Therefore, we have had to implement this system to cut down on further abuse.
b) The prices for no shows, cancellations, and rescheduling are based on the fee schedule shown below.
c) To schedule the initial office visit, it is understood that you are in agreement with these policies and that you agree to be held accountable for the charges shown on the fee schedule.

New Patients, Basic or Complex Types, and Foreign Patients

New Patients, Basic Type: The initial 1½ to 2 hour office visit will require a *non-refundable pre-payment scheduling fee of $750.*

New Patients, Complex Type: Complex Patients are defined as patients who have been to many other doctors, who have obtained many tests in the past, who have undergone many types of treatments, and who now want Dr. Neubrander to review everything and take over their child's case. A Basic Patient requires about 2 hours to complete a physical exam, review an *uncomplicated* past medical history, and review *basic* laboratory findings. A Complex Patient is one that will require significantly more time than the usual 2 hours required by a Basic Patient. *Complex cases include excessive amounts of time by the doctor* to review past medical history, lab data, MRI and EEG results, audiology reports, consultant's notes, diagnostic evaluations, therapies, treatment plans, IEPs, school programs, dietary plans, and other information parents present. Complex patients will be charged for the amount of time the doctor spends on the case based on his hourly rate of $400 per hour. The fee will be charged to the credit card on file once the total time required, and any subsequent charges, have been finalized. Unfortunately, there is no way to predict how much time will be required to complete the process. *Therefore, we discourage parents who have seen other Defeat Autism Now (the term used in the past and called a DAN doctor") doctors from becoming patients of Dr. Neubrander unless they understand and accept that this transition process is one that will require several hours of the doctor's time and therefore will be expensive.*

New Patients Who Speak Limited English: Another type of Complex Patient refers to patients whose language is a barrier. When a patient has limited or no understanding of the English language, the doctor is unable to quickly and efficiently communicate his findings to the patient at the consultation. Having to speak slowly or having to repeat himself over and over with a patient who has limited working knowledge of the English language requires a tremendous amount of additional time. Working through an interpreter is cumbersome and takes twice the amount of time. Therefore, we discourage parents who have a significant language barrier from becoming patients of Dr. Neubrander unless they understand that this problem is one that will require extra time from the doctor, not only at the initial office visit but for all future consultations, and that they will be charged for this extra time.

New Patients: No Shows, Cancellations, or Rescheduling Fees:

a) For a new patient that "No Shows", the non-refundable pre-payment *scheduling fee* of $750 will not be returned.
b) To call to reschedule an initial office visit 4 calendar days or more before the initial appointment: $0 rescheduling fee.
c) To call to reschedule an initial office visit 3 calendar days or less before the initial appointment: $375 rescheduling fee.

[Each of these cancellation fees will be charged immediately to the credit card on file]

Existing Patients: No Shows, Cancellations, or Rescheduling Fees:

No Show	less than 24 hours	Full Cost of the Scheduled Appt
Cancellation	less than 24 hours	Full Cost of the Scheduled Appt
Rescheduling	less than 24 hours	Full Cost of the Scheduled Appt
		Reschedule/Cancellation Fee
Rescheduling	24 – 48 hours	A scheduled 10 to 30 min Appt = $0
&		A scheduled 45 min Appt = $100
Cancellations		A scheduled 60 min Appt = $200
		A scheduled 75 min Appt = $300
		A scheduled 90 min Appt = $400

For all rescheduling or cancellations, if we are called between 24-48 hours prior to the appointment, a $200 credit [minimum unit time slot equivalent based on the rate of $400 per hour] will be issued to the scheduled cost for the appointed time slot.

		Reschedule/Cancellation Fee
Rescheduling	48 – 72 hours	Scheduled 10 to 30 min Appt = $0
&		Scheduled 45 min Appt = $0
Cancellations		Scheduled 60 min Appt = $100
		Scheduled 75 min Appt = $200
		Scheduled 90 min Appt = $300

For all rescheduling or cancellations over 72 hours, no fees are assessed.

Reschedule/Cancellation Fees are Waived if Serious or Unforeseen Illness, Injury, or Death Occurs to a Patient, Patient's Family, or Responsible Party.

Special Considerations Regarding Phone Consultations, Faxing, Scheduling Errors, and Considerations that are Optional for Foreign Patients

1. Time slots scheduled for phone consultations will be charged at the full price "**IF"** the doctor is ready for the consultation and the patient does not call on time. The same applies if the patient needs to email information during the scheduled appointment time because the original email was not sent "48-business hours" ahead of the scheduled appointment time. This is the amount of time that guarantees that the staff has enough time to call the patient to let him or her know that the email was incomplete or defective. We strongly recommend that patients scheduling Monday morning phone consultations pay special attention to this paragraph. They should make sure that they plan well ahead of time and finish their Checklist items by Wednesday night so that the staff can receive the documents on Thursday, thereby guaranteeing enough time for the staff to call back and notify you if there are any problems requiring a re-fax. ***PLEASE NOTE***: the doctor's clock is set by standard "cell phone, TV, or computer times", not by "the kitchen clock". Therefore, please check the time on your cell phone or from the guide available on your TV in order to call exactly at the time scheduled. Please note that it is from the scheduled time that the phone consultation begins.

2. It is the patient's responsibility to remove all previously scheduled appointments from the doctor's schedule book to avoid a no show charge. Whenever you remove previously scheduled appointments, the staff member you talk with indicates this on the appointment that was in the calendar. The record remains with the cancellation notation in the calendar so that there is no confusion.

***IMPORTANT*:** It is our desire to never have to enforce these policies. However, we have found that patients schedule appointments more thoughtfully and cancel appointments less frequently and less easily when money is involved. We have also found that patients do not schedule huge blocks of time without first considering the financial consequences they will face should they need to cancel and reschedule. Unfortunately, when a patient cancels an appointment that was scheduled for a huge block of time, it affects our office in a very negative way no matter how legitimate the reason was for the cancellation. Therefore, it is important for all patients to understand that the more time they schedule for an appointment, the more difficult it is for the staff to refill that slot. It is also important for all patients to understand that the closer to a scheduled appointment date they cancel or reschedule their appointment, the harder it is for the staff to refill that time slot. Therefore, our office policy must be one that works together out of mutual respect, not only to each other, but also for all the other families who would have scheduled were the time slot available and who now cannot use that time slot because not enough time is available.

Patients from Foreign Countries, Optional and Required Considerations

Optional: Whenever possible, families should plan on staying in America for two to four weeks. This is the amount of time required to obtain blood, urine, saliva, hair, or fecal specimens, have them sent to the laboratories, and guarantee the specimens were received in satisfactory condition. If there are any problems, this is enough time for the specimens to be resubmitted before the patient returns home. In general, for American or Canadian patients, the doctor does not order many laboratory tests at his initial office visit. However, due to the difficulties that may occur in order to get specimens to various laboratories in the United States from other countries, parents may want to obtain these specimens before they leave the States. A "safe" guess for how much time is needed is two to three weeks. During this two to three week period of time, if the doctor and parents

want to complete intravenous challenge tests, these can be performed in the doctor's IV department. For parents wanting to complete Dr. Neubrander's soft chamber "diagnostic protocol" for hyperbaric oxygen therapy (HBOT), four weeks is the necessary amount of time required to complete the process.

Required: Prior to scheduling with the doctor, it is the patient's responsibility to make sure there will be no problem getting medications through customs. Our office has no way to guarantee that medications can be received in a timely manner if there are custom issues in the patient's country. It is the patient's responsibility to make sure that there will not be long delays from the time a medication arrives at customs until the time it is released from customs. Long delays may render the medication no longer useable. Any patient wanting to work with Dr. Neubrander must understand these limitations prior to starting treatment and work towards resolving problems before they arise.

Fee Schedule for the Physician Assistant

General Information for patients from the US

a) Initial Office Visit: $325 [not based on time spent in consultation]
b) Follow-up visits and phone consultations: Based on a $175/hour fee schedule.
c) Phone consultations are based on actual time spent on the phone *plus* the additional time it takes for the PA to finish completing the Sign-out.
d) Office visits are scheduled with a minimum 30-minute time slot and then additional time allotments in 15-minute increments.

Miscellaneous Information

a) Phone calls received for cancellations or for rescheduling are documented by a time stamp by our phone system. If you call and reschedule directly with a staff member, an email confirmation will be sent to you documenting the time of the call. If you cancel by voice mail or email, the date and time will be documented from the time stamp by answering machine or email. If you ask to reschedule for a certain date by voice mail or email, the date and time will also be documented from the time stamp by answering machine or email.
b) Scheduled appointments are best "guess-timates" for the amount of time needed for simple and routine cases for the type of consultation it was anticipated to be. However, if the appointment cannot be completed within the scheduled time, for whatever reason, including additional questions and concerns that the parents want answered, the doctor will either...

i. End the consultation before it is finished and have the patient reschedule additional time in order to complete the unfinished portion of the appointment.
ii. Spend the entire allotted time reviewing lab data, explaining treatment options, etc., and complete the write-up portion of the signout at a later time.

c) Cases that turn out to be complex or that need more time to complete, for whatever reason, will be billed at the customary PA rate for the extra time that is needed to complete the write-up process at a later point in time.
d) The amount of time it takes to do the write-up to complete the signout varies greatly. The amount of time required is directly related to the complexity of the case and how much the doctor must do to finish the job with excellence. There is no way to predict what this will be ahead of time so the doctor and PA cannot agree to finish within a certain amount of time due to financial reasons by the parents.

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Definitions:

a) 0:00 hours to 24 hours is what is referred to as less than 24 hours.
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c) 48 hours and 1 minute to 72 hours is what is referred to as 48 to 72 hours.
d) A 7-day advance notice is 7 full calendar days.

Credit Cards and Billing:

a) Credit cards are now accepted for all services.
b) Payment is due at time of service. Billing never occurs, either to patients or to insurance companies.

Medicare and Medicaid:
a) The doctor/PA is not a Medicare Provider and therefore does not keep a UPIN number.
b) The doctor/PA does not treat Medicare or Medicaid patients unless done outside of the system as a “private pay” arrangement.

No shows, cancellations, and rescheduling:
a) All appointments missed will be billed as a "no show" on the day of the no show. Only severe weather and true family or medical *emergencies* will be accepted as reasons not to keep an appointment. Documentation of the emergency will be required to have the no show charge credited to your account. We do not like having to do this. However, too many patients have abused the system by calling and saying they have "an emergency." Therefore, we have had to implement this system to cut down on further abuse.
b) The prices for no shows, cancellations, and rescheduling are based on the fee schedule shown below.
c) To schedule the initial office visit, it is understood that you are in agreement with these policies and that you agree to be held accountable for the charges shown on the fee schedule.

New Patients, Basic or Complex Types, and Foreign Patients

New Patients, Basic Type: The initial 1½ to 2 hour office visit will require a *non-refundable pre-payment scheduling fee of $325.*

New Patients, Complex Type: Complex Patients are defined as patients who have been to many other doctors, who have obtained many tests in the past, who have undergone many types of treatments, and who now want Dr. Neubrander's Physician Assistant to review everything and take over their child's case. A Basic Patient requires about 2 hours to complete a physical exam, review an *uncomplicated* past medical history, and review *basic* laboratory findings. A Complex Patient is one that will require significantly more time than the usual 2 hours required by a Basic Patient. *Complex cases include excessive amounts of time by the doctor/physician assistant* to review past medical history, lab data, MRI and EEG results, audiology reports, consultant’s notes, diagnostic evaluations, therapies, treatment plans, IEPs, school programs, dietary plans, and other information parents present. Complex patients will be charged for the amount of time the physician assistant spends on the case based on his hourly rate of $175 per hour. The fee will be charged to the credit card on file once the total time required, and any subsequent charges, have been finalized. Unfortunately, there is no way to predict how much time will be required to complete the process. *Therefore, we discourage parents who have seen other Defeat Autism Now doctors from becoming patients of Dr. Neubrander's office unless they understand and accept that this transition process is one that will require several hours of the physician assistant's time and therefore will be expensive.*

New Patients Who Speak Limited English: Another type of Complex Patient refers to patients whose language is a barrier. When a patient has limited or no understanding of the English language, the physician assistant is unable to quickly and efficiently communicate his findings to the patient at the consultation. Having to speak slowly or having to repeat himself over and over with a patient who has limited working knowledge of the English language requires a tremendous amount of additional time. Working through an interpreter is cumbersome and takes twice the amount of time. *Therefore, we discourage parents who have a significant language barrier from becoming patients of Dr. Neubrander's practice unless they understand that this problem is one that will require extra time from the physician assistant, not only at the initial office visit but for all future consultations, and that they will be charged for this extra time.*

Updated January 1, 2012

New Patients: No Shows, Cancellations, or Rescheduling Fees:

a) For a new patient that "No Shows", the non-refundable pre-payment *scheduling fee* of $325 will not be returned.
b) To call to reschedule an initial office visit 4 calendar days or more before the initial appointment: $0 rescheduling fee.
c) To call to reschedule an initial office visit 3 calendar days or less before the initial appointment: $162.50 rescheduling fee.

[Each of these cancellation fees will be charged immediately to the credit card on file]

Existing Patients: No Shows, Cancellations, or Rescheduling Fees:

No Show	less than 24 hours	Full Cost of the Scheduled Appt
Cancellation	less than 24 hours	Full Cost of the Scheduled Appt
Rescheduling	less than 24 hours	Full Cost of the Scheduled Appt
		Reschedule/Cancellation Fee
Rescheduling	24 – 48 hours	A scheduled 10 to 30 min Appt = $0
&		A scheduled 45 min Appt = $43.75
Cancellations		A scheduled 60 min Appt = $87.50
		A scheduled 75 min Appt = $131.25
		A scheduled 90 min Appt = $175

For all rescheduling or cancellations, if we are called between 24-48 hours prior to the appointment, a $137.50 credit [minimum unit time slot equivalent based on the rate of $275 per hour] will be issued to the scheduled cost for the appointed time slot.

		Reschedule/Cancellation Fee
Rescheduling	48 – 72 hours	Scheduled 10 to 30 min Appt = $0
&		Scheduled 45 min Appt = $0
Cancellations		Scheduled 60 min Appt = $43.75
		Scheduled 75 min Appt = $87.50
		Scheduled 90 min Appt = $131.25

For all rescheduling or cancellations over 72 hours, no fees are assessed.

Reschedule/Cancellation Fees are Waived if Serious or Unforeseen Illness, Injury, or Death Occurs to a Patient, Patient's Family, or Responsible Party.

Special Considerations Regarding Phone Consultations, Faxing, Scheduling Errors, and Considerations that are Optional for Foreign Patients

1. Time slots scheduled for phone consultations will be charged at the full price "**IF"** the physician assistant is ready for the consultation and the patient does not call on time. The same applies if the patient needs to email information during the scheduled appointment time because the original email was not sent "48-business hours" ahead of the scheduled appointment time. This is the amount of time that guarantees that the staff has enough time to call the patient to let him or her know that the fax was incomplete or defective. We strongly recommend that patients scheduling Monday morning phone consultations pay special attention to this paragraph. They should make sure that they plan well ahead of time and finish their Checklist items by Wednesday night so that the staff can receive the documents on Thursday, thereby guaranteeing enough time for the staff to call back and notify you if there are any problems requiring a re-fax. ***PLEASE NOTE***: the physician assistant**'s** clock is set by standard "cell phone, TV, or computer times", not by "the kitchen clock". Therefore, please check the time on your cell phone or from the guide available on your TV in order to call exactly at the time scheduled. Please note that it is from the scheduled time that the phone consultation begins.

2. It is the patient's responsibility to remove all previously scheduled appointments from the physician assistant's schedule book to avoid a no show charge. Whenever you remove previously scheduled appointments, the staff member you talk with indicates this on the appointment that was in the calendar. The record remains with the cancellation notation in the calendar so that there is no confusion.

***IMPORTANT*:** It is our desire to never have to enforce these policies. However, we have found that patients schedule appointments more thoughtfully and cancel appointments less frequently and less easily when money is involved. We have also found that patients do not schedule huge blocks of time without first considering the financial consequences they will face should they need to cancel and reschedule. Unfortunately, when a patient cancels an appointment that was scheduled for a huge block of time, it affects our office in a very negative way no matter how legitimate the reason was for the cancellation. Therefore, it is important for all patients to understand that the more time they schedule for an appointment, the more difficult it is for the staff to refill that slot. It is also important for all patients to understand that the closer to a scheduled appointment date they cancel or reschedule their appointment, the harder it is for the staff to refill that time slot. Therefore, our office policy must be one that works together out of mutual respect, not only to each other, but also for all the other families who would have scheduled were the time slot available and who now cannot use that time slot because not enough time is available.

Patients from Foreign Countries, Optional and Required Considerations

Optional: Whenever possible, families should plan on staying in America for two to four weeks. This is the amount of time required to obtain blood, urine, saliva, hair, or fecal specimens, have them sent to the laboratories, and guarantee the specimens were received in satisfactory condition. If there are any problems, this is enough time for the specimens to be resubmitted before the patient returns home. In general, for American or Canadian patients, the physician assistant does not order many laboratory tests at his initial office visit. However, due to the difficulties that may occur in order to get specimens to various laboratories in the United States from other countries, parents may want to obtain these specimens before they leave the States. A "safe" guess for how much time is needed is two to three weeks. During this two to three week period of time, if the physician assistant

and parents want to complete intravenous challenge tests, these can be performed in the physician assistant's IV department. For parents wanting to complete Dr. Neubrander's soft chamber "diagnostic protocol" for hyperbaric oxygen therapy (HBOT), four weeks is the necessary amount of time required to complete the process.

Required: Prior to scheduling with the physician assistant, it is the patient's responsibility to make sure there will be no problem getting medications through customs. Our office has no way to guarantee that medications can be received in a timely manner if there are custom issues in the patient's country. It is the patient's responsibility to make sure that there will not be long delays from the time a medication arrives at customs until the time it is released from customs. Long delays may render the medication no longer useable. Any patient wanting to work with Dr. Neubrander's physician assistant must understand these limitations prior to starting treatment and work towards resolving problems before they arise.

Updated January 1, 2012

HARD CHAMBER FEE SCHEDULE: one price -- $125/hour

SOFT CHAMBER FEE SCHEDULE

"AT HOME" RENTAL PROGRAM
Included in the price:

a) $3000 for the "diagnostic protocol month".

b) Training by our staff to be *technically safe* to operate the chamber at home.

c) Training by our staff to be *medically safe* to put a child in the chamber in a home situation.

d) *The first no charge consultation with Dr. Neubrander* after the 30th hour, 10th day to review the child's initial progress, and to add any other treatments that may be necessary to help the HBOT treatment be more effective.

e) *The second no charge consultation with Dr. Neubrander* three weeks after ending the HBOT 30 day diagnostic treatment protocol. This is the point in time that the overall progression of the treatment effects can be identified. Dr. Neubrander will compare the child's overall progress to the progress seen from hundreds of other children with similar diagnoses who followed the HBOT diagnostic treatment protocol exactly the same way.

"IN HOUSE" DIAGNOSTIC PROTOCOL PROGRAM AT OUR CLINIC.

This program has been created for patients from other countries or other states who cannot rent a chamber to complete the 30 day soft chamber diagnostic protocol in their homes. The families come to New Jersey for 30 days. During that time, they use our office and our chambers the same way they would have used them at home. Due to the cost, convenience, and amenities, we recommend that they stay at Ronald McDonald House when they come.

Included in the price:

a) $1800 for the "diagnostic protocol month".

b) Training by our staff to be *technically safe* to operate the chamber at home.

c) Training by our staff to be *medically safe* to put a child in the chamber in a home situation.

d) Laundry for chamber linen sheets and pillowcases.

e) *The first no charge consultation with Dr. Neubrander* after the 30th hour, 10th day to review the child's initial progress, and to add any other treatments that may be necessary to help the HBOT treatment be more effective.

f) *The second no charge consultation with Dr. Neubrander* three weeks after ending the HBOT 30 day diagnostic treatment protocol. This is the point in time that the overall progression of the treatment effects can be identified. Dr. Neubrander will compare the child's overall progress to the progress seen from hundreds of other children with similar diagnoses who followed the HBOT diagnostic treatment protocol exactly the same way.

Patients that have completed the soft chamber diagnostic protocol through our clinic qualify for the maximum discount whenever they do hard chamber sessions.

January 1, 2012

Dear Prospective New Patient,

I am excited to meet with you and your child in a few weeks to months from now. We are seeing each other because we share a common goal, that goal being to help your child move forward toward recovery! Neither of us knows how little or far your child may progress over the next few years, but I can assure you that as we work together using sound scientific principles, even though not yet proven by double-blind, placebo-controlled studies, we will be a lot closer to your child's ultimate potential than we would have been if we did nothing at all. I offer no promises and no guarantees. Neither do I believe in giving false hope. What I can offer is total commitment on my part to do everything I can for your child, as well as for your entire family, during the time we spend together, whether it be weeks, months, or years. Unfortunately, during our first visits together we will not have enough time to do more than begin the process as we attempt to unlock your child's mind. Hopefully, what I share with you during our initial time together and during our subsequent follow-up appointments will *allow us to begin the necessary next steps on your child's road toward recovery.*

Before we meet, it is important for me to put things into perspective so you will not have unfulfilled expectations. The best analogy I can use to build the bridge we need to cross the river that separates your expectations from reality is the analogy of going to school. When we begin working together, we are essentially starting "first grade". As you know, an education takes years to acquire. So it is with the multiple biochemical, biological, and electrochemical categories that we will need to attack and conquer for your child. When we begin this process, though mild changes in your child's symptoms will most likely occur soon after you start working with me, in general, major changes will take months before they are realized, and near-recovery or recovery will take no less than 2 to 4 years to achieve, if it is even a possibility with your child. To see significant changes will require *continuous and ongoing effort.* It will demand *tedious and hard work*. Most of the time, *progress will be slow*. At times, the results you see will be small when compared to how hard you are working to get them. When this happens, parents often get discouraged and quit running their marathon race at the halfway or three-quarter mark. This is unfortunate because *the race is worth running*. Your child needs you to *run it*. Your child needs you to *cross the finish line*. There is no magic bullet. There is no miracle seed that is planted today and blossoms tomorrow. When I meet you, I will be enrolling your child in Autism Recovery School. This school will also take years of hard work and study in order for your child to graduate. Not all children can be honor students. However, as your child follows the right guidance, excellent teachers, attends class, and does the homework required, it would be a rarity for your child not to graduate. Graduation does not mean complete recovery, though that is not impossibility. Graduation means that your child will be able to function at a much higher level than he or she would have been able to function if you did little or nothing biomedically and electrochemically along the way. For those of you who have yet to do anything, I welcome you to my school. For those of you who have already been doing many things with little success and feel stuck, together we will review your child's case with the hope of finding new clues to lead us forward in a new direction with new perspectives on yet an unexplored path. Whether new to

the process or a seasoned veteran, it will be our goal to get a glimpse of what are the possibilities that may unlock the door imprisoning your child.

I look forward to our time together.

Sincerely yours,

James A. Neubrander, M.D.