OZONE THERAPY CONSENT FORM

Please read carefully, and sign and initial below:

I _____ understand that Ozone is a gaseous molecule consisting of pure oxygen that stimulates the body's natural healing processes. I understand the therapy I will receive today utilizes Ozone, which will be mixed with my blood drawn today in the office. That mixture will then be administered via intravenous catheter into my vein, muscle, or joint. Ozone Therapy is believed to have health-promoting effects; such as stimulating immune function to fight chronic and acute infections, boosting energy, alleviating pain and weakness, and frailties of aging. I am aware this therapy provides wellness and is not approved for medical necessity. Infusion Wellness Center does not claim to treat, cure, or prevent disease or sickness. I am aware that Ozone Therapy is NOT approved by the FDA.

_____I understand the possibility of a severe allergic reaction to this treatment. I understand this includes the potential, although rare, anaphylactic shock that can be life-threatening.

_____ I understand rare, potentially life-threatening, side effects may include shortness of breath, blood vessel swelling, poor circulation, heart problems, and stroke. I understand more common side effects may include burning and stinging at the injection site or surrounding tissue, muscular spasms, weakness, fatigue, and/or local thrombophlebitis. The nursing staff and provider may be unable to anticipate all risks and complications associated with my treatment, and I am relying on their professional abilities to make proper judgment based on my medical history that I have provided, as well as my best interest.

_____ I understand the risk of Jarisch- Herxheimer reaction. This was explained to me as an infectious organism which die off, and cause symptoms of detoxification. This may cause mild to moderate flu-like symptoms including but not limited to fever, chills, pain, aching, headache, fatigue, lethargy, rashes, and phlegm.

_____ I agree that I was fully informed of the protocol and risks for the treatment I will receive today. I've been given the opportunity to discuss my concerns, and all have been addressed to my satisfaction prior to my treatment. I assume full liability for any adverse effects that may result in non-negligent administration of the proposed therapy. I waive the claim in law or equity for redress of any grievance that I may have concerning or resulting from the therapy, except that pertains to negligent administration of this therapy. I agree to release and hold harmless all practitioners, consultants, associates and staff from any and all liability associated with the procedure(s) that I receive. I understand that I have sought treatment using ozone therapy and have not been forced to do this.

_____I acknowledge no guarantees have been made to me concerning the results of this treatment. I do not expect the nurse or provider to anticipate all risks and complications, but to exercise their best judgment in treatment recommendations suited for me based on the medical history I have provided.

_____ I verify that all information presented regarding my medical history is true to the best of my knowledge and I am not misrepresenting my current health status or medical history. It is my responsibility to keep my medical provider up to date with all of the current medications and supplements that I am taking, so that he/she can make the best-informed recommendations for my care.

Attention to Cancer Patients:

_____ Our approach does not involve direct cancer treatment. Rather, we focus on enhancing the immune system's responsiveness to cancer. The restoration of the immune system to optimal function is central to the healing process. Once the patient's immune system reaches sufficient strength, it becomes better equipped to address the challenges posed by cancer.

Notice of Privacy Practices

Your health information may be used by staff members or disclosed to other health care professionals for the purpose of reviewing your health, and providing therapies. Agents and assigns do not evaluate health or diagnose medical conditions. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals and employees who may provide therapies or who may be consulted by staff members. Appointment reminders: Your information will be used by our staff to send you appointment reminders. You have the right to receive a printed copy of this notice.

By signing this consent form I have agreed to the following: I have been informed of my rights, understand the therapy I am about to receive, and I authorize and consent to the therapies.

PRINT NAME: _____

SIGNATURE: _____ DATE: _____

FOR PERSONS UNDER 18

If you are under 18 and receiving treatment, please print your name below and have your guardian or parent print and sign.

PRINT NAME (Under 18): _____

PRINT NAME: _____

SIGNATURE: _____ DATE: _____

I have reviewed and approved the following consent form:

MD SIGNATURE: _____ DATE: _____