Private Non-Negotiable Contract

HYPERBARIC AND HIGH DOSE OZONE THERAPY CONSENT

My signature below requests and authorizes the administration of Hyperbaric Ozone Therapy (HBOT), inclusive of High Dose Therapy, by **North Florida Integrative Medicine (Dr. Anil George)**, and any and all medical personnel associated with Dr. Anil George.

Ozone High Dose Therapy (OHT) is a treatment pioneered by Johann Lahodny, MD of Vienna, Austria. We have modified it via Dr. Rowen's protocol to make it safer by using less heparin.

Purpose of Treatment: I understand that the purpose of this treatment is to assist my body to heal by taking advantage of the benefits of ozone therapy, including, but not limited to: immune modulation, circulation improvement, better oxygen delivery and consumption, and assistance to my body with infection. I understand that with any alternative treatment, other factors may affect the outcome.

Description of Therapy: Materials and Methods: Using a small, sterile IV catheter, 200cc of blood is withdrawn under vacuum into a glass bottle with heparin, an anticoagulant derived from pigs. 200cc of medical grade ozone/oxygen gas mixture is then added and mixed into the blood under pressure. The blood is then immediately returned to the patient under positive hyperbaric pressure. This constitutes "one pass." This treatment can then be repeated up to nine (9) more times for a total of ten passes, sometimes more, if possible. The estimated number and frequency of infusions has been discussed with me, but there is no maximum, minimum, average, or expected number. *I agree to stay for the time necessary after treatment until I confirm no adverse reaction at the time of leaving the office.*

NO FDA Approval: I am aware of and specifically understand that the Food and Drug Administration (FDA) has not approved any ozone/oxygen mixture as administered in this procedure as method of preventing, improving, treating, or curing any condition. I am aware that The National Registry and FDA state that ozone has no indications and is a dangerous gas. I acknowledge that no promises or guarantees have been or will be made by the medical professionals or staff regarding the outcome of this or any subsequent treatments. I understand that it is possible that there will be no effects from the treatment and that I may be delaying other "approved" or conventional approaches.

Alternatives: I have had the opportunity to consult other physicians and healthcare providers prior to seeking this alternative treatment. There may be other conventional methods of treatment that have been specifically explained to me by other healthcare professionals and I have had the opportunity to ask all the questions that I deemed appropriate regarding other treatments and had the answers to my questions explained by them.

Risks: I understand that although it is not possible to predict every side effect associated with this therapy, any reactions are expected to be transient and may include chest tightness and pressure, coughing, shortness of breath, facial flushing, hypotension, or limb weakness without loss of motor function or strength (paresthesia). Other short-term side effects that have been reported, but are not

limited to, include Herxheimer reactions, fatigue, headaches, bruising, pain from the needle stick, vein discomfort, and localized phlebitis. I understand I could have an acute exacerbation of an existing condition from ozone therapy. I understand there is always a risk of the unknown or unexpected reaction, even severe or life-threatening adverse effects, including blood clots, embolism, and death.

If I am on a class of drugs called **ACE Inhibitors** (Vasotec, Lotensin, Capoten), I have informed or will inform in the future the medical staff, practitioner, or RN who will be administering my treatment.

We use **Heparin**, an anticoagulant **derived from pigs**, generally no more than 6,500 units but up to 12,000 units, to “thin the blood” to prevent clots. Heparin decays by half per hour and is thus gone in a few hours. It can be reversed with a drug called Protamine, derived from fish, which we have available if necessary. Our treatment bottles have **synthetic “latex”** which is approved for medical use. I attest that I have informed the staff administering the treatment if I have an allergy to pork, fish, heparin, latex, or a bleeding disorder or if I am currently having my menses. I acknowledge knowing that heparin may make menses heavier temporarily. I agree to inform my nurse or practitioner if I have taken **prescription blood thinners** of any kind within 5 days prior to my treatment.

I will inform the medical staff if I have had any injury or fall since yesterday, especially to my head and I will do this before future treatments as well. I understand the risk that if I fall or cut myself during the 6-8 hours following the treatment, I may have significant bleeding due to the heparin. I understand that if I strike my head that I could have a life-threatening bleed into my brain and I should get medical attention immediately. I agree to inform a healthcare provider if I am involved in an accident within 8 hours after my treatment since I received heparin.

After the therapy, it is normal to see “blood-tinged” urine, which should last for no more than a few hours but may continue overnight. There is no known significance or danger from this occurrence. The IV line and/or catheter could clot during the treatment and there is the risk of losing the remaining blood in the bottle or IV line. Loss of this blood would be expected to have negligible health effects. Tumors of any kind have a higher risk of bleeding by its nature. If you have cancer, the tumor and its metastases could bleed, leading to death, stroke, or shock.

Information, Preparation, and Communication: I provided accurate information regarding my health status, medical history, and reasons for participating to the staff. I agree to prepare myself for the treatment as directed by the staff. It will be my responsibility and obligation to discuss any reaction or side effects in a timely manner with the staff/ provider.

Acknowledgement and Consent: I have read (or had read to me) and understand all aspects of this informed consent form. I know I can discontinue treatment at any time. I have questions which have not been answered to my full satisfaction. I understand and accept the above risks and give my consent to receiving high dose hyperbaric ozone therapy. I release Dr. Anil George, his medical personnel, his medical staff and the doctor’s heirs and the staff’s heirs from any and all liability for any untoward reaction that might result from these therapies. This is binding on my heirs.

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Printed Patient (*or Guardian*) Name and Signature Date