HYPERTHERMIC OZONE AND CARBONIC ACID TRANSDERMAL TECHNOLOGY (HOCATT) CONSENT FORM

I wish to use the HOCATT to improve my fitness level/receive physical therapy. Before entering the program I understand that I will need to complete a medical history form for the purpose of detecting any condition, which may indicate that I should not participate in a fitness program or that my program may need to be altered. I understand that withholding information about my health may result in an incorrect exercise prescription, which may cause harm to me.

I understand that if I have certain pre-existing medical problems, or if concerns develop during the course of my health history, the staff will request information from my physician, and will request his/her consent for my participation. I understand the staff will review all data submitted and develop a safe and effective exercise program for me. All information received or generated about me is strictly confidential.

I understand that no assurance can be given to me that participation in a fitness program will increase my functional/athletic capacity, improve my blood sugar and blood pressure, assist in weight loss and tone my muscles; however current research indicates that improvement in these areas can be achieved with active participation in an exercise program. In addition, feelings of increased confidence and a sense of well-being usually occur.

The exercises are designed to place a gradually increasing workload as tolerated on my cardiovascular and musculoskeletal system and thereby improve its functioning. The reaction of my body cannot be accurately predicted. I understand the risks associated with exercise include blood pressure abnormalities, lung congestion, irregular heartbeats, muscle pain and soreness, and in very rare instances a "heart attack", "stroke" or "cardiac arrest."

I understand that the staff will take all measures to avoid such happenings. I understand that providing the staff with current information about changes in my health, which includes any illness or symptoms I experience in the performance center or at home, is essential for the Anil George MD PA staff to determine if any modifications need to be made in my HOCATT program. I understand that if I do not inform the Anil George MD PA staff that I may be putting myself at risk for injury or serious medical problems.

I understand that I am required to respect the rights of all participants and staff members involved with the Anil George MD PA. I understand that the staff has the right to address concerns about my health with my physician and may ask to temporarily discontinue my exercise program until my physician evaluates my condition and advises me on my return.

I acknowledge that no guarantees can be made to me as a result of my participation in the program. I hereby release Anil George MD PA, its affiliated entities, employees, trustees and their respective representatives and agents from all claims, liabilities, and causes of action arising or associated with my participation in this program. I have read the foregoing or it has been read to me, and I understand its contents and significance.

Client/ Participant/ Guardian's Signature: _____ **Date:** _____

Witness/ Practitioner's Signature: _____**Date:** _____