CONSENT FOR OZONE THERAPIES AND I.V. NUTRIENT THERAPIES

I, _____,

understand that Isadora Guggenheim, FNP are recommending one or more ozone therapy(s) and or nutrient therapy(s) for me. Ozone therapy was not suggested to me in place of traditional therapies that have been recommended to me. I understand that ozone therapy can be used in conjunction with traditional methods and medicines. Guggenheim have not suggested that I forgo any treatment protocols, surgeries or pharmaceuticals recommended to me to treat my condition(s). These therapies, although not recognized by conventional medicine actually have a 50 year track record of safety and efficacy. Guggenheim is certified in Ozone Therapy and Prolozone Therapy by the American Academy of Ozone Therapy. They have taken continuing medical education workshops and seminars which emphasize and teach the safest and most optimal applications of these therapies.

I understand that these treatments will enhance cellular oxygen utilization, blood flow, cellular healing and pain relief. By way of protein-like molecules called cytokines, these therapies stimulate immune system activity. I have been explained that the type and dose of activated oxygen therapy I receive will promote cellular regeneration and immune modulation. Ozone stimulates the immune system so it can target pathogens be it pathological viruses, fungi and bacteria.

Ozone Therapies are beneficial to a broad constellation of medical conditions. To the extent that they enhance tissue oxygenation and blood flow, ozone therapy relieves pain and inflammation, up-regulates antioxidant enzyme defenses and stimulates immune function. I understand this research has been profusely documented in peer-reviewed medical and scientific journals for decades and that the therapies Guggenheim has advocated for are in no way unproven, dangerous or experimental when administered within the limits and standards of their training. I understand that I am encouraged to research ozone therapies and their side effects prior to deciding if this treatment is right for me.

I understand that should I have any of the following conditions, ozone therapy is contraindicated and may not be appropriate for me: pregnancy, thyrotoxicosis, hemophilia, porphyria with u.v. blood irradiation, severe acute disc herniation, extremely low platelet count, acute heart attack, acute stroke, acute fracture**. I understand that I am not a candidate for ozone, prolozone or any I.V. therapy if I have ANY medical condition that necessitates receiving emergency care.** I understand that as with any intravenous therapy, I might experience transient hypoglycemia or low blood sugar, headache, and light-headedness, local swelling, bruising or irritation at the intravenous insertion site, hematuria (blood in urine) or a slight hemolysis if I have a G6PD deficiency.

I am not pregnant to my knowledge and I understand that if I am pregnant or think I am remotely pregnant, I am NOT a candidate for Ozone therapy. I understand that I am responsible to disclose this informations prior to any treatment. Guggenheim are is responsible for any outcomes that result in the lack of disclosure.

Disclaimer: We will not administer any I.V. therapies if a patient is hypoglycemic, hyperglycemic, has acute unstable blood glucose, unstable cardiac issues, delirium, acute respiratory issues, pregnancy, acute bleeding disorder, acute mastocytosis, acute allergic reaction, under the influence of alcohol and/or of illegal/mind altering drug(s) including cannabis. We have full control to make decisions regarding all I.V. therapies/procedures to uphold patient safety. We may require specific labs prior to an I.V. procedure. Patients may not demand or dictate for specific treatments. Guggenheim reserves the right to refuse treatment to any patient violating any of the above and below stated requirements.

I have been advised to eat and drink prior to my I.V. therapy.

I understand that Guggenheim makes no guarantee(s) about these therapies with respect to my condition(s). **I understand that I have not been guaranteed a cure for my condition(s) nor was I directed to stop or not proceed with any other treatments recommended to me for my condition(s).** I do, however; understand the broad application of these therapies to optimize oxygnenation states, which is one of the underlying abnormality in almost every chronic disease. _____(initial)

DESCRIPTION OF INTRAVENOUS THERAPY

An Ozone-Oxygen gaseous mixture will be introduced into a designated vein, commonly in the arm, using a sterile angiocatheter. The amount and strength of ozone used is a clinical judgment by the qualified practitioner and will be based upon your individual needs. There is no set amount of treatments. The exact number and frequency of infusions will be discussed with you as well as any additional component in each infusion i.e homeopathics, peptides, glutathione, ultra violet blood irradiation. _____ (initial)

I understand ozone therapy is NOT a replacement for chemo therapy, radiation and/or surgery. I understand that I should consult with my physician(s) and oncologist(s) before and during ozone therapy treatments. ____(initial)

NON INTRAVENOUS OZONE THERAPY

Insufflation and ozone injections into soft-tissue area(s), ear(s), eye(s), bladder, vagina, rectum, prostate, abdomen, perineum, scar tissue, and/or lipoma(s). I understand that infusion therapies are not recommended as a replacement treatment for any surgical therapies, chemo therapies or pharmaceutical therapies that have been suggested to me. ____ (initial)

PROLOZONE THERAPY

The injection of ozone and anti-inflammatory and/or proliferative formula(s) into designated joint(s). This may also include the patient's own plasma enriched platelets. I understand that I may experience site pain and/or bruising after my prolozone injection. _____(initial)

POST VACCINE PROTOCOL – Initial only if receiving post vaccine protocol

I understand that if I am receiving the Post Vaccine Protocol, administered by Isadora Guggenheim, FNP, that there are no guarantees that this protocol will eliminate any/all of the side-effects experienced by any particular vaccine. We are not responsible for any subsequent vaccine injury(s) or side-effects. I understand that the post vaccine protocol does not involve receiving a vaccination. Vaccinations must be administered by your general practitioner, pediatrician or vaccine facility prior to receiving the protocol.
____(initial)

NO FDA APPROVAL

I am aware of and specifically understand that the Food and Drug Administration has not approved the Ozone-Oxygen mixture to be administered as a method of treating, curing, or preventing disease. I voluntarily agree to get ozone therapy treatment. No promises have been made to me or implied by the doctors, nurses or staff regarding the outcome of this treatment.
_____ (initial)

ALTERNATIVES
I have the opportunity and am encouraged to consult other physicians and health care providers regarding my condition for alternative methods of treatment. I have not been instructed to end treatment with any of my current physicians or health care providers. _____ (initial)

RISKS
Guggenheim follows standard of care treatment as outlined & required by The American Academy of Ozone Therapists. Any and all side effects of the therapies have been explained to me by the staff and doctors. I have sought this treatment of my own free will and assume responsibility for all risks and side effects involved. _____ (initial)

MEDICAL INFORMATION AND EXAMINATION
I have been asked to provide accurate information regarding my past and current health status and medical history. I will provide copies of all relevant blood work, imaging, pathology reports and other doctors' notes. I understand each of these requirements and have agreed to comply with them. ____ (initial)

I understand that it is my responsibility to disclose any and all conditions that have been contraindicated with ozone therapies. Isadora Guggenheim, FNP is not responsible for any side effects that occur due to my lack of disclosure. _____ (initial)

I have sought medical care from Isadora Guggenheim, FNP of my own free will. Guggenheim is trained in both allopathic medicine and natural medicines which include: herbs, vitamins, minerals, enzymes, peptides, bio-identical hormones,ozone therapies and nutraceuticals to promote and restore a healthy balanced body. Guggenheim emphasizes the importance of non-toxic remedies as the therapeutic mainstay for restoring patients to their optimal state of health to be used with your current treatment protocols.

I realize that this integrated approach to medical therapy may not be as rapid as pharmaceutical or surgical therapy and it may require more effort from me than the simple administration of medication(s) for each medical condition. Ozone therapy was not suggested to me by Guggenheim as a replacement for surgical therapy, chemo therapy, radiation therapy, pharmaceutical therapy or any other treatment protocols. I have not been instructed to stop taking any medications prescribed to me. ____ (initial)

I understand that this is a non-refundable service. I am seeking this treatment of my own free-will and understand there are no guarantees being made and there are potential side effects as with most forms of treatment. This type of treatment is NOT covered by insurance. There are no procedure codes for ozone therapy, therefore we will not be able to provide reciepts with CPT codes to be utilized for insurance reimbursment. We will only provide receipts for personal records, health savings and tax purposes. ____(initial)

I am not consulting with Guggenheim in order to provide any information to any enforcement, regulatory or investigative agency of any kind. ____ (initial)

I have read, understood and agreed to all of the above policies. ____ (initial)

I _____ give my consent to Isadora Guggenheim, FNP to give me one or multiple activated oxygen therapies, IV nutrient therapies, Prolozone treatments.

Print Name: _____

Signature: _____ Date: _____
Patient (Parent/guardian's signature if patient is a minor)