NEW IMAGE HEALTH & WELLNESS

HIGH DOSE OZONE THERAPY INFORMED CONSENT

Client Information

First Name: _____

Last Name: _____

Date of Birth: _____

Phone Number: _____

Email: _____

Address: _____

Preferred Contact Method: _____

Introduction
This document provides information about High-Dose (HD) Major Autohemotherapy (MAH) and Ultraviolet Blood Irradiation (UBI) with intravenous administration. Please read carefully and ask any questions before treatment.

Purpose of HD O3UV
This procedure involves withdrawing approximately 300 mL of blood, exposing it to medical-grade ozone and ultraviolet light, and then reinfusing the treated blood. The therapy is intended to support oxygen utilization, circulation, immune function, and overall wellness.

Procedure Description
1. Approximately 300 mL of blood is withdrawn using an infusion pump.
2. Blood passes through UV light and is mixed with medical-grade ozone.
3. The treated blood is reinfused through an IV line.
4. Treatment generally lasts 60–75 minutes.

Potential Benefits
• Enhanced immune system function
• Improved oxygenation and circulation
• Support for detoxification processes
• Potential reduction in symptoms related to chronic inflammation or infection
• Improved energy and wellness

Potential Risks and Side Effects
• Pain, bruising, bleeding, or infection at IV site
• Allergic reaction (rare)
• Dizziness, lightheadedness, vasovagal response, or blood sugar changes
• Hemolysis if excessive ozone concentrations are used
• Herxheimer reaction (temporary worsening of symptoms)
• Fatigue or malaise following treatment
• Rare or unforeseen complications

Alternatives
Conventional medical care, other ozone therapies, lifestyle modification, or no treatment.

Contraindications
• Current antibiotic use
• Medications causing light sensitivity
• G6PD deficiency
• Heparin allergy or anticoagulant sensitivity
• Ozone sensitivity
• Severe cardiovascular disease
• Hyperthyroidism
• Bleeding disorders
• Recent heart attack or stroke
• Severe anemia
• Acute alcohol intoxication
• Pregnancy or breastfeeding

Patient Responsibilities
Inform your provider of all medications, supplements, and treatments. Follow all instructions and report adverse reactions immediately.

Confidentiality
Medical records and treatment information will be maintained in accordance with applicable privacy laws.

CONSENT STATEMENT

By signing below, I acknowledge that: 1. I have read and understood the information provided above. 2. I have had the opportunity to ask questions and have received satisfactory answers. 3. I understand the potential benefits, risks, and alternatives associated with High Dose Major Autohemotherapy and UBI treatment. 4. I voluntarily consent to undergo High Dose Ozone Therapy treatment. 5. I understand that I may withdraw my consent at any time prior to treatment without penalty.

Client Signature: _____

Printed Name: _____

Date: _____

Staff/Witness Signature: _____

Date: _____