NEW IMAGE HEALTH & WELLNESS

STANDARD OZONE / UV IV 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 Ozone/UV IV Therapy, including Major Autohemotherapy (MAH) and Ultraviolet Blood Irradiation (UBI). Please read carefully and ask any questions before consenting to treatment.

Purpose of O3UV Therapy
O3UV therapy involves withdrawing a small amount of blood, mixing it with medical-grade ozone, and reinfusing the treated blood through an intravenous system utilizing ultraviolet blood irradiation. This therapy is intended to support oxygen utilization, circulation, immune function, and overall wellness.

Procedure Description
• Approximately 60–120 mL of blood will be withdrawn using sterile technique.
• The blood is mixed with a specific concentration of medical-grade ozone.
• The treated blood is then reinfused through an IV line utilizing UV therapy.
• The treatment generally lasts 30–60 minutes.

Potential Benefits
• Enhanced immune system support
• Improved oxygenation and circulation
• Potential reduction in symptoms associated with inflammation or chronic infections
• Support for detoxification pathways
• Improved energy and wellness

Potential Risks and Side Effects
• Pain, bruising, bleeding, or infection at the IV site
• Allergic reactions (rare)
• Dizziness, lightheadedness, or fainting
• Hemolysis if excessive ozone concentrations are used
• Herxheimer (detoxification) reaction
• Fatigue or malaise following treatment
• Rare or unforeseen complications

Alternatives
Alternative options may include conventional medical treatment, other ozone therapies, lifestyle modifications, nutritional support, or no treatment.

Contraindications
Please notify your provider if you have any of the following: • Current antibiotic use
• Medications causing photosensitivity
• G6PD deficiency
• Allergy to heparin or anticoagulants
• 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 pre- and post-treatment instructions.
• Report any adverse reactions or concerns immediately.

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

Consent Statement
By signing below, I acknowledge that:

• I have read and understood the information provided.
• I have had the opportunity to ask questions.
• I understand the potential benefits, risks, and alternatives associated with Ozone/UV IV Therapy.
• I voluntarily consent to undergo treatment.
• I understand that I may withdraw consent at any time prior to treatment.

Client Signature: _____

Printed Name: _____

Date: _____

Provider/Witness Signature: _____

Date: _____