5191 S Yosemite St, Suite B
Greenwood Village, CO 80111
303-577-9977
www.integrativehealthinc.com

Integrative Health Inc

Contraindications to HBOT

In the use of hyperbaric oxygen therapy, there are certain conditions and medications that would preclude the therapy.

- Upper respiratory infections and chronic sinusitis make it difficult for the patient to clear their ears. The Equalizer or decongestants can be used to open the sinuses, and occasionally ear tubes are necessary to maintain open Eustachian tubes. It is better to interrupt treatment for several days to allow the respiratory infection to clear.

- High fever can predispose to oxygen seizures but in such cases drugs can be given to lower the fever.

- In some patients with severe emphysema and COPD the only stimulus to breathe is hypoxemia, as they have lost their sensitivity to normal levels of CO-2. These patients may cease breathing if placed in the hyperbaric chamber.

- Patients who have a lower than normal seizure threshold may be more prone to develop seizures due to oxygen toxicity. Additional anticonvulsants can be added to these patients' regimens.

- HBOT treatment is absolutely contraindicated for patients with pneumothorax, a condition in which air or gas with fluid is present in the chest cavity, and caution is used with HBOT treatment if a patient has a history of spontaneous pneumothorax.

- HBOT is not recommended for patients with optic neuritis, as it can make this condition worse.

- Medications that would preclude HBOT are: Doxorubicin (Adriamycin), Cisplatinum, Bleomysin, Disufiram (Antabuse) and Mafenide Acetate.

If a woman is pregnant, HBOT is not recommended for precautionary reasons.

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HBOT - Patient Liability Release

Name (First and Last): _____

DOB: _____ Phone:_____

Address: _____

Email: _____@_____

I, _____, living at _____, understand and accept the following:

1. _____ Hyperbaric Oxygen Therapy (HBOT) is a relatively new form of treatment and that there are certain risks inherent with a new form of treatment.

2. _____ I currently take the following prescription and over the counter medications:

   _____
   _____

   _____ I currently take the following vitamins, minerals and nutritional supplements.

   _____
   _____

3. _____ In partial consideration for receiving this treatment, I agree to assume all risks arising from HBOT and to hold _____ harmless for any side effects or risks associated with this treatment. Specifically, I agree to assume any and all risks of any effects or risks, be they primary, secondary, side, known or unknown, associated with this treatment and hereby release _____ from any and all claims, suits or causes of action arising out of or related to any such risks.

4. _____ In executing this liability release, I acknowledge I have been informed that the following effects and risks of this treatment have been observed in others who have received this treatment and I acknowledge that these are among the risks and effects that I have assumed, and against which I am holding _____ harmless:

a) Pain in the ears or sinuses;

b) An increase in the fluid in the ear;

c) Vision difficulties including nearsightedness or a worsening of cataracts;

d) Numbness in the fingers and toes;

e) Interaction of any medication or supplement with the oxygen;

f) Lowering of blood glucose for diabetic patients;

g) Seizures

h) Fatigue

5. _____ In executing this liability release, I acknowledge that I have been informed and understand the following:

a) Ear pressure equalization procedures;

b) Nutritional needs prior to each HBOT treatment;

c) Blood glucose level monitoring and control during HBOT treatment of diabetic patients;

d) Smoking restrictions while receiving HBOT treatments;

e) Procedures for HBOT treatment of children under 18 years of age.

I understand that there is also a chance that the increased levels of oxygen in my body can cause oxygen toxicity or lung problems, and that there are no guarantees that this treatment will improve my condition.

_____ _____

Patient / Parent / Guardian Signature Date

Disclaimer:

Consult a doctor before pursuing any form of medical treatment, including hyperbaric oxygen therapy.
The information provided within this form is not to be considered medical advice.
Hyperbaric oxygen therapy is considered investigational, experimental, or off label by the FDA for many conditions.

Please consult with your treating medical physician before undergoing hyperbaric oxygen therapy.

Integrative Health Inc
Experts Providing Healthcare

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Mild Hyperbaric Therapy Consent Form

The technology, known as mild Hyperbaric Therapy (mHBT), has been reported to have beneficial effects for a wide range of conditions, without negative side effects. Nevertheless, as with many treatments, there are areas of concern which you should be aware. It is important that you take a few minutes to read the following information.

OTIC BAROTRAUMA: Is a condition of injury to the eardrum, and is extremely unlikely to occur in the mild hyperbaric chamber. However, severe ear discomfort can be caused if you cannot equalize the pressure in your ears. As the chamber is pressurized and depressurized you must be able to equalize the pressure in your ears to acclimate to the pressure changes. You will most likely experience "popping" in your ears. This is normal. You can assist the equalization process by yawning, chewing, swallowing, working your jaw side to side and up and down, turning the head side to side and ear to shoulder. Sitting upright in the chamber during pressurization and depressurization will generally also make the equalization process more comfortable. In general, doing whatever assists you being comfortable when taking off and landing in a plane may be most effective for you. Continue to do this as needed for the duration of pressurization and depressurization. When the chamber reaches full pressure and again when the chamber is completely deflated there should be no additional pressure in the ears**.**

IF YOU ARE UNABLE TO EQUALIZE EAR PRESSURE AND EXPERIENCE PAIN IN ONE OR BOTH EARS, IT IS CRITICAL THAT YOU COMMUNICATE ANY DISCOMFORT IMMEDIATELY TO THE STAFF. This will give us the opportunity to make adjustments in the pressurization or depressurization process to eliminate discomfort. If you are unable to equalize the pressure in your ears the visit will be immediately terminated. If this happens or if pain persists beyond the visit, we recommend that you consult your physician to evaluate and alleviate the situation before attempting another visit.

EAR, SINUS AND/OR THROAT CONGESTION, HEAD COLDS, VIRUS OR PRIOR TRAUMA TO THE EARS: You may consider rescheduling your visit in the chamber if you are suffering from any of these conditions. Discomfort from these conditions is less frequent but may occur**.**

IF YOU ARE UNABLE TO EQUALIZE EAR PRESSURE AND EXPERIENCE PAIN IN ONE OR BOTH EARS, IT IS CRITICAL THAT YOU COMMUNICATE ANY DISCOMFORT IMMEDIATELY TO THE STAFF so we can assist you or terminate your visit**.** We recommend you consult your physician in order to alleviate the underlying condition before attempting another visit.

PULMONARY HYPEREXPANSION: This condition is very rare under mild hyperbaric treatments. However, to be overly cautious, **HOLDING YOUR BREATH DURING DECOMPRESSION MUST BE AVOIDED** as it could lead to expansion of the air in your lungs and damage to the lung tissues. In the highly unlikely event of an unexpected rapid decompression, it is critical that you exhale immediately.

MEDICATIONS: mild Hyperbaric Therapy may enhance the effectiveness or increase the metabolism (decrease the effectiveness) of any medication you are taking. **IT IS RECOMMENDED THAT YOU HAVE THE DOSAGE AND FREQUENCY OF ALL MEDICATIONS MONITORED AND ADJUSTED REGULARLY BY YOUR PHYSICIAN**.

PREGNANCY: **MILD HYPERBARIC THERAPY IS NOT ALLOWED DURING THE FIRST TRIMESTER.** After this time it may be beneficial to both mother and child.

INITIALS _____

SEIZURES: mild Hyperbaric Therapy is not associated with causing or inducing seizures. To be on the cautious side we have established a seizure protocol that involved reaching full pressure(4.2psi) and spending full treatment time (standard 1 hour) in the chamber over a series of staged visits**. IF ANYONE IN GETTING IN THE CHAMBER IS SEIZURE PRONE, THE STAFF MUST BE MADE AWARE PRIOR TO THE FIRST VISIT.** If a seizure is experienced in our clinic, unless otherwise instructed (and a waver is signed), our procedure is to call 911, remove the patient from the chamber and make the individual as comfortable as possible.

DETOXIFYING OR CELL DIEOFF: mild Hyperbaric Therapy may assist the body to naturally detoxify and balance digestive flora. **AN INDIVIDUAL MAY EXPERIENCE SOME DISCOMFORT FROM THIS PROCESS IN AS LITTLE AS 1 TO 36 HOURS AFTER TREATMENT**. Symptoms may include; flu like symptoms, loss of appetite, stomach ach, constipation, diarrhea, headache, behavioral issues etc. Although unpleasant, this is a natural process and continuing treatments may be of benefit to more rapidly accomplish a positive result. However **IF SYMPTOMS PERSIST, WE RECOMMEND CONSULTING YOUR PHYSICIAN TO EVALUATE AND ALLEVIATE THE SITUATION BEFORE ATTEMPTING ANOTHER VISIT**.

PNEUMOTHORAX: mild Hyperbaric Therapy is contraindicated for an existing pneumothorax (collapsed lung). **IF YOU HAVE A PNEUMOTHORAX OR SUSPECT THAT A PNEUMOTHORAXIS AN ISSUE, YOU WILL NOT BE ALLOWED IN THE CHAMBER UNTIL YOU/WE RECEIVE A DOCTOR'S CLEARANCE.** If you have experienced a pneumothorax in the past and have already been "cleared from your doctor" to resume normal activity, once you have provided a written confirmation you should be able to proceed with mild Hyperbaric Therapy you should be able to proceed with mild Hyperbaric Therapy.

COMPRESSIVE BRAIN LESIONS - SUBDURAL HEMATOMA, INTERCRANIAL HEMATOMA: mild Hyperbaric Therapy is contraindicated for existing compressive brain lesions (subdural hematoma, intercranial hematoma). **IF YOU HAVE COMPRESSIVE BRAIN LESIONS OR SUSPECT THAT COMPRESSIVE BRAIN LESIONS ARE AN ISSUE, YOU WILL NOT BE ALLOWED IN THE CHAMBER UNTIL YOU/WE RECEIVE A DOCTOR'S CLEARANCE.** If you have experienced compressive brain lesions in the past and have already been "cleared from your doctor" to resume normal activity, once you have provided a written confirmation you should be able to proceed with mild Hyperbaric Therapy.

DIABETES / INSULIN DEPENDANT: Insulin dependency may result in a drop in blood sugar while in the chamber. **IT IS CRITICAL THAT YOU IMMEDIATELY COMMUNICATE TO THE STAFF IF YOU EXPERIENCE OR ANTICIPATE AN EPISODE. YOUR TREATMENT WILL BE TERMINATED.** You are required to; A) take a blood sugar reading prior to your treatment (if below 150, you must have a snack prior to treatment) and again after your treatment (if below 150, you must have a snack prior to leaving). B) Take a protein bar and a juice box (or whatever you use if faced with a "drop" in the normal management of your condition) into the chamber with you.

SENSITIVITY TO CHEMICALS (MCS) / ODORS / ALLERGY: Avoid wearing heavy colognes as the smells may linger in the chamber and have an adverse effect on another patient**. IF YOU EXPERIENCE ADVERSE SENSITIVITY OR HAVE ALLERGIES THAT MAY BECOME AGGRAVATED WHILE IN THE CHAMBER, LET THE STAFF KNOW PRIOR TO YOU VISIT OR AS SOON AS POSSIBLE WHEN IN THE CHAMBER SO MEASURES CAN BE TAKEN TO ASSURE YOUR COMFORT OR IF YOUR VISIT NEEDS TO BE TERMINATED.** We recommend that you wearing a charcoal mask or filter if it is known to assist your condition. If these sensitivities persist and you cannot exist comfortably in the chamber, you will need to consult your physician in order to alleviate the underlying condition before attempting another visit.

I have read and fully understand the above information.

Signature _____
Date: _____/_____/_____

PRIVATE LICENSE

The undersigned hereby grants a Private License to Integrative Health Inc to provide mild hyperbaric therapy to the undersigned. The undersigned acknowledges that Integrative Health Inc and its agents do not diagnose neither prescribe for medical or psychological conditions nor claim to prevent, treat, nor cure any condition. Its agents do not provide diagnosis, care, treatment or rehabilitation of individuals, nor does Integrative Health Inc or its agents apply medical, mental health or human development principles, but rather provides mild hyperbaric therapy technology that may benefit.

The undersigned acknowledges giving Informed Consent to the services that will be provided. The undersigned hereby releases Integrative Health Inc and its agents from all claims and liabilities arising from the use or misuse of hyperbaric therapy indemnifying and holding Institute and its agents harmless from all claims and liabilities wherefrom, whatsoever. The Institute and its agents reserve all rights.

In the unlikely event that the client has a dispute with Integrative Health Inc, the client agrees that the dispute shall be settled by arbitration through the Better Business Bureau of Metropolitan _____.

I (print name)_____ have read, fully understand and consent to treatments in the mild hyperbaric chamber. I have also completed the health questionnaire which accompanies this consent form, and I agree to hold Integrative Health Inc harmless from blame regarding hyperbaric therapy services provided by Integrative Health Inc.

Although mild hyperbaric therapy has been reported to be beneficial for a wide range of conditions, this therapy is not meant as a cure for any condition or disease and no therapeutic outcomes can be guaranteed. We do not in any way recommend hyperbaric therapy as a substitute for any medical treatments prescribed or suggested by any medical physician. We do not make any guarantees to any results that an individual may experience. We are NOT medical practitioners. We do not accept insurance for our services.

Signature _____

Printed Name: _____

Date: _____/_____/_____

HEALTH INFORMATION AUTHORIZATION FORM

Patient Name: _____
Date of Birth: _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES INTEGRATIVE HEALTH INC TO USE AND / OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING: SPECIFIC AUTHORIZATIONS

☐ I give permission to Integrative Health Inc to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related information, about treatment alternative, or other health related information.

Initial _____

€ Integrative Health Inc to leave a phone message on my answering machine or voice mail.

Initial _____

☐ I give Integrative Health Inc permission to provide hyperbaric therapy in an open room where other patients are also receiving hyperbaric therapy. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.

Initial _____

Signature _____

Date: _____/_____/_____

PROMOTION AND DOCUMENTATION AUTHORIZATION FORM

Patient: _____
Parent or Legal Guardian: _____

To assist in the promotion and documentation of our services here at the center, we request permission to photograph you and/or your child. This photograph may be used, along with your name and testimonial, in printed form on display in our center, in printed form on display during promotional events around the country, in digital form on educational CDs or on our website.

SPECIFIC AUTHORIZATIONS

☐ **I give Integrative Health Inc permission to use my photograph or my child's photograph in printed form on display at the center or during promotional events.**

Initial _____

☐ **I give Integrative Health Inc permission to use my name and/or my child's name in printed form on display at the center or during promotional events.**

First names only Initial _____

Both first and last name Initial _____

☐ **I give Integrative Health Inc permission to use all or part of my testimonial in printed form on display at the center or during promotional events.**

Initial _____

☐ **I give Integrative Health Inc permission to use my testimonial in digital form on a promotional / educational CD or on our website.**

Initial _____

By signing this form you are giving Integrative Health Inc permission to use and disclose your protected health information in accordance with the directive listed above. You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, Integrative Health Inc will not refuse to provide treatment. You have the right to revoke this AUTHORIZATION at any time. Details will be provided upon your request.

Signature _____

Printed Name: _____

Date: _____/_____/_____