HYPERBARIC OXYGEN THERAPY (HBOT)

CONSENT & AGREEMENT to TREATMENT

**********Please read and acknowledge each of the following statements below by signing below.**

***_____ I understand that mild hyperbaric oxygen therapy is not intended to diagnose, treat, or cure or prevent disease. In addition, I recognize that while mild hyperbaric oxygen treatment MAY ENHANCE healing, it does not replace a health professional's prescribed medications or recommended treatments. Health professionals prescribe a wide variety of health issues: however, I acknowledge HBOT therapy is only approved for specific conditions by the FDA.**

***_____ I understand that HBOT Mild uses an increase of atmospheric pressure in a sealed chamber to allow the body to absorb more oxygen (approximately 91%) at a cellular level to promote healing and wellness. I understand that the amount of atmospheric pressure use by Wellness by Stephanie, is 1.3 absolute atmospheres, or 4.4 psi, at minimum, based on your condition and reaction to treatment, these depths can be increased up to 2.0 absolute atmospheres, or 14.3 psi.**

***_____ I understand that Mild HBOT is reported to be beneficial for a wide range of medical ailments, but no therapeutic outcomes can be guaranteed and is case-by-case basis. And, those fees are rendered for services, and not case-by-case outcome or benefits received. I procure and acknowledge that therapy is at my own risk, and I understand, in some cases no benefit may be gained and is directly linked to the condition of the individuals' health or complications of their condition. I acknowledge that while the FDA recognizes certain specific conditions, there are several "off-label" conditions, which have been studied and found to have positive results. I understand that HBOT treatment does**

***_____ I understand that the chamber is pressurized and depressurized and I may experience discomfort in one or both ears, or sinus, and may need to "pop" the ear by holding and blowing nose, just like the feeling you would have on an airplane. I understand in the event that I cannot stabilize pressure in my ear or ears, treatment can be stopped. There are adjustments on the machine that can be made in addition if necessary.**

***_____ I attest that I am a consenting adult over the age of 18, and I agree to enter and or agree to allow my child to enter the mild HBOT of my own free will. I am entering the chamber at my own free will and risks, and do agree not to touch or handle any knobs or buttons, seals or door of chamber, due to the risk of damaging the equipment or breaking the compression which could damage my ears etc.**

***_____ I agree that for several minutes after HBOT DIVE, I will continue to breath the oxygen to prevent hypoxia (a drop in O2, that can cause dizziness and other complications within the first minutes exiting the Chamber to normal Atmospheric pressure).**

Notes: special considerations and needs

*_____ I am not aware of any medical conditions that would prevent me or otherwise, preclude me, or have been told of from my physician, not to partake from HBOT Adjunct Therapy. I am entering the HBOT Chamber at my own desire and without coercion or sales pressure.

*_____ If any doubts, concerns, or questions, I will discuss it with my physician. Any Treatment of 2.0 atmospheres requested will require a Prescription by your Physician.

ACKNOWLEDGEMENT OF POLICIES: (Please Initial Each)

- I AGREE NOT TO BRING FOOD OR DRINK INTO CHAMBER, UNLESS I AM DIABETIC.
- I AGREE TO HAVE CLEAN BODY, HAIR, AND COTTON CLOTHING ONLY
- I AGREE TO NO FLAMEABLE OR SHARP ITEMS.
- I UNDERSTAND THAT IT IS IMPORTANT TO EAT AT LEAST ONE HOUR PRIOR TO ENTERING CHAMBER, AND TO HAVE USE THE BATHROOM ACCORDINGLY.
- I UNDERSTAND THAT SMOKING AND NICOTENE CAN INHIBIT HBOT ADJUNT THERAPY, I AGREE TO OBSTANE FROM SMOKING OR NICOTENE PATCHES AT LEAST 2 HOURS PRIOR TO HBOT.

By signing and dating this consent, I attest, that I acknowledging and in agreement to and understanding, and am consenting to Therapy in this Spa. That I have fully read and understand all information within it, and that I am assuming any and all risks associated with the administration of HBOT, I agree to each item in this agreement and consent, I do not hold Wellness by Stephanie liable in any way.

Printed Name ____________________ Signature ____________________

Date: ____________________ address: ____________________

I agree to allow WBS to use my photos or likeness on Media: ____________________

Authorized Representative: ____________________

Date: ____________________

CLIENT INTAKE FORM

Be Well Now, A Healthy Lifestyle Center
221 E. Center Dr. Alton, IL 62002 618-462-3900

Thank you for your visit. We sincerely hope, based upon our experience and certified training, that the massage you receive will help you on your way to a more relaxed, healthy and sound way of living.

Please take a few moments to fill out this form. It will enable us to give you the therapy best suited for your specific needs. If you have an existing medical condition you feel may be adversely affected by massage, please feel free to telephone your physician prior to your massage. We encourage you to do so; a relaxed mind is the beginning of a wonderful massage!

Name____________________ Birth Date____________________

Address____

City/State/ZIP______________________________________

Email____

Phone (Home)______________ (Work)______________ Occupation______________

Primary reason for appointment______________________________

Areas of complaint, pain or tension____________________________

Who recommended you?________________________________

What medications do you take?______________________________

Any recent surgery or acute injuries?____________________________

Any type of breast surgery? YES NO What kind?______________ When?______________

Prostate surgery? YES NO Chemotherapy? YES NO Radiation? YES NO When?______________

Have you had one or more lymph nodes removed? YES NO Where?____________________

Your Physician's name and town______________________________

Spinal Problems? YES NO Arthritis? YES NO Where?____________________

Heart Problems? YES NO Blood Pressure? YES NO Varicose Veins? YES NO Blood Clots? YES NO

Are you pregnant? YES NO Contact Lenses? YES NO Dentures YES NO Skin Problems or Allergies? YES NO

Have you had a professional massage before? YES NO When?____________________

PLEASE READ AND SIGN

I understand that the massage therapy given here is for the purpose of stress reduction, relief from muscular discomfort and for increasing blood, lymph and energy circulation. I further understand the massage therapist does not diagnose illness, disease, or any other physical disorder. As such, the massage therapist does not prescribe medical treatment or medication(s) and does not perform spinal manipulation. It has been made clear to me that massage therapy is not a substitute for medical examination or diagnosis. I have to the best of my knowledge, stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

Signature____________________________ Date____________________