Mild Hyperbaric Oxygen Therapy (m-HBOT)
Informed Consent & Release of Liability Patient Information

Acknowledgement of Nature of Therapy

☐ I understand that Mild Hyperbaric Oxygen Therapy (m-HBOT) involves breathing 100% oxygen in a pressurized chamber (typically at 1.5 ATA) to increase oxygen saturation in body tissues. I acknowledge that while m-HBOT is reported to have beneficial effects for a wide range of conditions, it is not intended to diagnose, treat, cure, or prevent any disease.No therapeutic outcomes are guaranteed, and this therapy is not a substitute for prescribed medical treatments.
Understanding of Risks and Side Effects *Required*

☐ I have been informed of the potential risks and side effects associated with m-HBOT, including but not limited to: • Barotrauma: Pain or injury to the ears or sinuses due to pressure changes; inability to equalize pressure may result in discomfort or injury. • Oxygen Toxicity: Although rare at mild pressures, risks include seizures or lung irritation. • Vision Changes: Temporary myopia (nearsightedness) that may resolve weeks after treatment cessation. • Other: Claustrophobia, fatigue, dizziness, nausea, or hypoglycemia (especially in diabetics). • Fire Risk: Strict precautions are taken, but oxygen supports combustion; I agree to follow all safety protocols (no ope flame, no sharp objects, no smoking, and no self modification (changing anything) in the chamber).
Contraindications and Health Disclosure *Required*

☐ I certify that I have disclosed all current medical conditions, medications, and therapies. I understand that m-HBOT may be contraindicated or require caution if I have: • A history of pneumothorax (collapsed lung) or recent thoracic surgery. • Congestive heart failure or severe lung disease (e.g., COPD, emphysema). • Uncontrolled diabetes or hypoglycemia. • Epilepsy or history of seizures. • Upper respiratory infections, sinus congestion, or ear infections. • Use of specific chemotherapeutics (e.g., Bleomycin, Disulfiram, Mafenide Acetate). • Pregnancy (unless specifically approved by a physician). Authorization and Privacy (HIPAA) *Required*

☐ I authorize the clinic to use and disclose my protected health information for treatment, payment, and healthcare operations. I consent to the release of

information to my referring physician if necessary. I understand that photos may be taken before, during, and after treatment for medical evaluation and confidentiality is maintained. Release of Liability and Indemnification *Required*

☐ I voluntarily agree to undergo m-HBOT. I acknowledge that I am entering the chamber at my own risk. I hereby release, indemnify, and hold harmless Triangle Holistic Health, its owners, employees, and agents from any and all claims, liabilities, damages, or causes of action arising from the use or misuse of m-HBOT, including any side effects or complications, except in cases of gross negligence or willful misconduct. Dispute Resolution *Required*

☐ Any disputes arising from this agreement shall be settled through binding arbitration in accordance with the laws of Maricopa County, Arizona. The clinic is not liable for damages exceeding the cost of the services rendered. Patient Declaration *Required*

Required Acknowledgment:
☐ I have read, understand, and voluntarily agree to the terms of this Informed Consent & Release of Liability.

Patient Name: _____

Date of Birth: _____

Signature: _____

Date: _____

Parent/Legal Guardian Signature (if applicable): _____

Relationship to Patient: _____

Date: _____