Hyperbaric Centers of Florida
21st Century technology in a safe and caring environment

Disclosure and Informed Consent for Hyperbaric Therapy

I, _____ request and authorize, or as the Legal Guardian for _____, my _____,
That I, or they be included as a patient for the use of Hyperbaric Therapy, a successful outcome cannot be guaranteed. If I am unable or unwilling to participate fully all treatments will be discontinued if either the attending physician or I reason that the hyperbaric treatments pose a danger to my welfare.

I understand that the procedures and risks related to Hyperbaric Therapy to be the following:

1. I will be placed in a hyperbaric Chamber that will be pressurized with compressed air to a pressure of up to three (3) atmospheres absolute, which is the amount of pressure used during treatment. During therapy in the Multiplace Chamber, I will be seated, and may be with other patients present, and will breathe pure oxygen using a plastic hood that covers my entire head. In the Monoplace Chamber I will rest in a reclining position on a gurney that slides into the steel and acrylic chamber. In either case, I will be able to communicate with the qualified attendant and/or operator during my entire treatment.

2. I have been advised that while dangers are minimal, it is possible that I may experience discomfort to my ears, sinuses, or teeth due to the change in barometric pressure. If such discomfort occurs, I will notify the attendant, who will stop the treatment until the problem has been resolved. I understand that some individuals who experience discomfort with their ears may require a myringotomy. An ear, nose and throat specialist generally performs this as an outpatient procedure. I understand that if this procedure is required, I will miss hyperbaric treatments until the procedure has been done.

3. If I have any lung abnormalities, it is possible that during decompression, I may experience problems due to the trapping of air in some part of the lungs. This may result in an arterial gas embolism, collapsed lung, or emphysema. While these problems may be serious, my physician is aware of these potential problems and does not believe that any pulmonary abnormalities exist.

Initials: _____ Date: _____/_____/_____

Hyperbaric Centers of Florida
21st Century technology in a safe and caring environment

4. I understand that if I am diabetic, I may be slightly more vulnerable to oxygen toxicity than a non-diabetic. However, I understand that I must eat shortly before coming for treatment, and I will have a source of glucose available during treatment.

5. I understand that positive results from Hyperbaric Treatment cannot by guaranteed. I understand that as in the administration of any medication, in some instances this treatment may not have the expected or anticipated benefits. However, the desired and expected results have been explained, together with the rationale for the use of hyperbaric therapy in my particular case.

6. I understand that hyperbaric therapy is usually considered to be an adjunctive treatment and is used in conjunction with other medical treatment. Therefore, I will not discontinue my other medication or treatment of my medical condition without my doctor's specific instructions. All intravenous medication will be interrupted during the actual hyperbaric treatment, but the IV line(s) need not be removed if properly capped.

7. I understand there are risks involved in any procedure or treatment, and it is not possible to guarantee or give assurance of a successful result.

8. I understand that it is not uncommon for the eyes to undergo minor refraction during and extended series of hyperbaric treatments. I understand that this change occurs more frequently in individuals **over the age of 50** than to those who are under the age of 50. I understand that these changes are usually temporary, and that after discontinuing treatment the eyes usually return to their previous condition.

9. I understand that after an extended series of treatments, I may notice numbness and tingling in my fingertips. I understand this is a temporary reaction and usually disappears after hyperbaric treatments are discontinued.

10. I understand that the use of certain medications is contraindicated during treatment with hyperbaric oxygen therapy, and I agree to inform the facility personnel of all medications that I am currently taking, or have taken in the last six months.

Initials: _____ **Date: _____/_____/_____**

Hyperbaric Centers of Florida
21st Century technology in a safe and caring environment

11. I consent to the photographing, filming, viewing or videotaping of the treatment of myself for educational use.

12. I am satisfied with my understanding of the nature of the procedure or treatment and all additional questions have been answered.

I HAVE READ AND UNDERSTAND THE EXPLANATIONS PROVIDED TO ME AND VOLUNTARILY AGREE TO PARTICIPATE IN THE TREATMENT PROGRAM.

Date: _____/_____/_____ Time: _____ AM PM

_____ _____

Signature Printed name

_____

Signature of Parent or Guardian

HYPERBARIC CENTERS OF FLORIDA, LLC

_____

Signature

_____ Date:_____/_____/_____

Title