

**INFORMED CONSENT FOR CHILD RECEIVING HYPERBARIC OXYGEN THERAPY**

I, \_\_\_\_\_ (parent's name), do hereby request that the EVND Treatment Center administer hyperbaric oxygen therapy (HBOT), to

\_\_\_\_\_ (patient's name), who is my child or legal dependent.

I will indemnify and hold harmless EVND Treatment Center for any complications that arise as a result of such treatments. These complications may include, but are not limited to, the following: barotrauma to the ears or sinuses, seizures, pneumothorax, and/or ocular effects (myopia or cataract growth). My child and I (or person accompanying the patient inside the chamber) have no known contraindications to receiving HBOT and have been cleared for treatment by a physician.

I understand that HBOT is considered an experimental treatment and results are not guaranteed. I agree to communicate any changes that occur in my or my child's health while receiving treatments and to seek appropriate medical evaluation when necessary. I understand that the treatments are administered by the trained staff of the EVND Treatment Center and that there may be no physician on site. I acknowledge that I have received a copy of the office policies and privacy statement and agree to the content of both. I also acknowledge that there is a 24 hour cancellation policy that is strictly enforced, details of which are included in the office policies. In full knowledge of the aforementioned facts and details, I give my permission and consent to proceed with hyperbaric treatment.

\_\_\_\_\_  
Adult Patient, Parent, or Legal Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Child or Dependent's Name

**INFORMED CONSENT FOR HYPERBARIC OXYGEN THERAPY**

I, \_\_\_\_\_ (patient's name), have been advised that the HBOT does have some risk, including barotrauma to the ears and sinuses caused by the change in pressure.

I acknowledge that if I have a sinus or ear infection arise during a scheduled series of treatments, that it is best to halt treatment until the infection has cleared. \_\_\_\_\_ Initial

I understand that some patients may experience changes in their vision during their treatment period, known as myopia. These changes are usually minor and temporary. \_\_\_\_\_ Initial

I have been informed that a rare side effect is oxygen toxicity which is caused by administering too much oxygen, resulting in seizures, convulsions, or difficulty breathing. However this is not expected due to the low pressures under 2 ATM and the short duration of treatment for 60 minutes. \_\_\_\_\_

I have discussed with the EVND Treatment center team that I have a negative history of seizures, mitochondrial disease, untreated pneumothorax (collapsed lung) or current cancer prescriptions. \_\_\_\_\_ Initial

I have been informed that risks of hyperbaric therapy also include seizures 0.01-0.03%(1-3/10,000). Risk is very low as current pressures are not to exceed 2 ATM for more than 60 minutes. \_\_\_\_\_ Initial

I understand that claustrophobia can occur and that I am able to stop treatment at anytime during the session before it has expired. \_\_\_\_\_ Initial

I understand that it is NOT recommended to do HBOT with a diagnosis of Lyme, Strep, or PANDAS until I have completed at least 3 months of the prescribed therapy. \_\_\_\_\_ Initial

\_\_\_\_\_  
Adult Patient, Parent, or Legal Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name

**OFFICE POLICY**

Welcome to the EVND Treatment Center. We are pleased that you have allowed us to help in the recovery of you or your child. We have created this facility in order to provide a much needed service to this area, as safely as possible, while keeping the overhead, and thus the cost, to a minimum. In order to do this we have had to adopt the following policies. We appreciate your understanding and cooperation in the administration of these provisions and vow to provide you with the best hyperbaric experience possible.

- All persons receiving treatment must have a prescription from a licensed physician on file prior to beginning therapy. The prescription can be as detailed as the referring doctor desires, or it can simply read "HBOT".
- Caregivers, who may enter the chamber to accompany the patient, must also have a note from a licensed physician stating that they have no contraindications to being put inside a hyperbaric chamber.
- All sessions must be paid in advance. To receive a package discount the entire payment must be received prior to beginning treatments. We accept Visa, MasterCard, Discover, and American Express. Personal checks are also accepted but will be cashed immediately. There will be a \$30 fee for returned checks.
- There is a 24 hour cancellation requirement. All sessions scheduled and not cancelled 24 hours prior to the scheduled treatment time will be charged for one hour of HBOT.
- All clients must have a signed consent form and office policies form on file prior to beginning therapy.
- Treatments will be administered by the trained staff of the EVND Treatment Center. There may not be a physician on site.
- If a package is purchased and the client is unable to finish the complete set of dives, then a refund may be issued. The amount of the refund will equal the price paid, divided by the total amount of sessions purchased, minus the number of sessions completed.
- Clients must wear either all cotton clothing or 50/50 cotton blends while in the chamber.
- Electronic equipment is allowed in our soft chambers which do not exceed 1.5 ATA.
- Clients are responsible for the care, cleaning, and storage of their own oxygen masks.
- I consent to receive notifications for scheduled appointments and other reminders pertinent to the continuity of care, via phone, email and/or text.

**I understand and agree to the above office policies.**

\_\_\_\_\_  
Adult Patient, Parent, or Legal Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name