Informed Consent

Date ________________________

Time ________________________

I do hereby authorize HYPERBARIC MEDICINE INC. and Dr. Albert E. Zant and Associates and Assistants to administer Hyperbaric Oxygen Therapy for my medical condition identified in this Patient Record produced and maintained by HYPERBARIC MEDICINE INC.

I am fully aware of all risks and benefits associated with receiving Hyperbaric Oxygen Therapy as they have been thoroughly explained to me so that I am able to make a choice to receive treatments(s) offered by HYPERBARIC MEDICINE INC. Furthermore, the immediate and practical risks including but not limited to Barotraumas (Damage to Ear Drum, Middle, or Inner Ear and to Sinuses), Confinement Anxiety, Oxygen Toxicity, Seizures, Pneumothorax (Collapse of the Lung), Ocular Change (Myopia or cataract growth), Fire, and consequences associated with these risks have been fully explained and understood by me.

The possibility of alternative forms of therapy, where they exist, have also been identified and elaborated, as have the potential complications of the various therapies for my medical condition. I acknowledge that no guarantee or assurance has been made to me of potential results from receiving Hyperbaric Oxygen Therapy or any other therapy from HYPERBARIC MEDICINE INC. and the Staff of HYPERBARIC MEDICINE INC.

I consent to following the advice and direction provided by the Staff of HYPERBARIC MEDICINE INC. to help provide optimum results from the therapy I receive. I agree that the Staff of HYPERBARIC MEDICINE INC. will prescribe the mode and manner of Hyperbaric Oxygen Therapy and any subsequent procedures necessary to my well being that may arise subsequent to such exposure.

For the purpose of advancing medical knowledge, I also consent to the admittance of any and all Medical and Nursing Students and other observers in accordance with the practices of HYPERBARIC MEDICINE INC.

AUTHORIZING SIGNATURE

Patient is alert and oriented to time and place ______________________________________ *Physician*

Patient Signature	**Address**
______________________________	______________________________
Authorized Agent	**Relationship to Patient**
______________________________	______________________________
Witnesses	**Address**
______________________________	______________________________
Witnesses	**Address**
______________________________	______________________________

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