ENHANCED WELLNESS *of* NEW MEXICO
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# INFORMED CONSENT *for* OZONE INJECTION

☐ I hereby request and consent to the performance of ozone injection, on me (or on the patient named below, for whom I am legally responsible) by Dr. Joseph Jaros or Dr. Jan Jay and/or other physicians who now or in the future work at the clinic or office listed above.

☐ I have had an opportunity to discuss with Dr. Jaros or Dr. Jay and/or with other office or clinic personnel the nature and purpose of ozone injection. I understand that results are not guaranteed.

☐ I understand and am informed that, as in the practice of medicine, in the practice of ozone injection there are some risks to treatment, including but not limited to infection, allergic reaction and local inflammation as well as a possible increase in pain for up to 5 days. I also understand that the injection mixture contains B vitamins, to which I have no known allergy.

☐ I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

☐ I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name (please print): .....

Patient or Guardian Signature ..... Date: .....