Patient Name____ Patient DOB_________________
(Please Print)

INFORMED CONSENT FOR TREATMENT WITH OZONE UBI

I hereby give my consent to YOO DIRECT HEALTH to administer BioPhotonic Therapy (BPT) with Ozone often referred to as Ozone & Ultraviolet Blood Irradiation (UBI). I have been informed and understand that this method involves removing a small volume of my own blood (from 30 cc to a maximum of 300cc's) under sterile conditions, briefly exposing that blood to selected frequencies of Ultraviolet Light and Ozone (O_3) molecules and re-infusing the blood back into the body. The blood will also be treated with a very small amount of temporary acting anti-coagulant (heparin).

I understand that BPT (Ozone & UBI) is used clinically as both a specific (ie psoriasis, lymph cancer) and non-specific (chronic infections, chronic fatigue, inflammation, auto-immune diseases, scleroderma, etc.) immune modulating therapy. Certain forms of auto-immune diseases, infections and tissue transplant rejection have all been published as benefiting from Biophotoinc - UBI therapy. Although there are many positive medical studies and testimonies, I realize that this alternative treatment is not guaranteed to cure or improve my condition.

I understand that the nonspecific use of BPT (Ozone & UBI) is "alternative" and is therefore **NOT COVERED BY MEDICARE, MEDICAID, OR PRIVATE INSURANCE.** I understand that BPT (Ozone & UBI) therapy is usually administered as a series of treatments, depending on the condition being treated. I understand that the side effects of BPT therapy include minor bruising at the injection site, potential minor bleeding from the heparin, mild temporary "healing reactions" (low grade fever, minor muscle aches or joint aches), possible prescription drug – BPT (Ozone & UBI) interaction (i.e. sulfa drugs, tetracyclines, phenothiazines) and the rare possibility of photo allergy in the case of allergy to sunlight. Other side effects although not listed in the literature may also be possible.

TRAINING ACADEMY

I understand that as part of Ozone therapy I am required to have labs drawn as part of the treatment plan. I understand that it is my financial responsibility to pay for these labs. I understand that my Ozone dosing will be determined by my provider and my progress.

Contradictions: Pregnancy, Breastfeeding, or planning to become pregnant. G6PD deficiency could lead to hemolysis. Prior to your first treatment labs will be drawn to check G6PD.

I have notified the provider/staff of ALL **PRESCRIPTION MEDICATIONS** I am currently taking **prior to Ozone UVBI therapy being administered.** I also understand that in the event of any adverse reaction after the first treatment that I am to contact this clinic for further instructions. If it is an emergency call 911.

I understand that **Yoo Direct Health** will monitor my treatment in an effort to prevent any side effects but cannot guarantee that I will not experience any side effects or adverse reactions. I understand that, as with any health treatment, there is no guarantee I will obtain satisfactory results through the use of this therapy. I understand the use of this treatment does not preclude me from using other treatments as well, though I recognize that I should inform any provider I am seeing about the various treatments I am using.

I have **READ, UNDERSTAND AND CONSENT** to the above.

Signature: ____ **Date:** ____________

Witness: ____

Provider Signature: ____ **Date:** ____________