**General Consent for Ozone**

**Consent for Treatment:**

\_\_\_\_\_\_ (Initials) I hereby voluntarily consent to care, treatment, testing, and all other services performed by Nutty Pagan/AcuWellness. At the same time, I do understand that I have the right to refuse consent to any proposed care or treatment. Moreover, I have the right to ask questions and discuss my concerns with my healthcare provider.

\_\_\_\_\_\_ (Initials) I am aware that Ozone Therapy is not FDA approved and is not an exact science. I acknowledge that no guarantees have been made to as to the outcome of my care, examination, and/or treatment at Nutty Pagan/AcuWellness.

\_\_\_\_\_\_ (Initials) While I understand that I am required to sign this consent annually or as necessary, I may revoke this consent at any time by writing to the Nutty Pagan/AcuWellness office. AcuWellness 106 Pilgrim Village Dr. Suite #400. Cumming, GA 30040.

**Release of Medical Information:**

\_\_\_\_\_\_ (Initials) I understand that Nutty Pagan/AcuWellness shall maintain both electronic and paper-based documentation of the treatments received. This record will typically include individually identifiable information about my symptoms and health condition; results of physical examinations and diagnostic tests; a plan regarding future care and treatment. Such information about me is protected health information (PHI) and as such, will be used, shared or disclosed only for the purpose of treatment, payment and healthcare operations.

**Video/Cameras/Recording:**

**\_\_\_\_\_\_** (Initials) I hereby voluntarily consent and understand that due to the nature of privacy of clients, the use of any video or sound recording is strictly prohibited. Any usage of recording devices will immediately be the severance of care by Nutty Pagan and the client. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sign

**Patient Rights and Responsibilities:**

\_\_\_\_\_\_\_ (Initials) I acknowledge that my healthcare is a partnership between Nutty Pagan/AcuWellness and myself; hence, I agree to actively participate and accept both my role and responsibility regarding my healthcare and the rights available to me.

**Patient Name (Print):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**