# Prolozone Consent Form

## Prolozone Consent Form

This document is a binding agreement (the “Agreement”) between Blessed Hands IV Hydration (“We” or “Us”) and the individual patient whose name and signature appears below (“You” or “Your”). In consideration of the health care services provided to You by Us at the present and at all times in the future, You agree as follows:

1. **Consent for Treatment.** You hereby authorized Us to provide You with health care treatment, including without limitation medical, diagnostic, nutritional treatment, (together the “Treatment”) administered by Us, physicians, or assistants. You understand that the practice of health care/medicine is not an exact science and that diagnosis and treatment may involve risk of injury or death. You acknowledge that we have not made any guarantees or promises as to the outcome or the safety and efficacy of the Treatment.

2. **Experimental Nature of Treatment.** You acknowledge and agree that the evaluation, diagnosis, and treatments may consist in whole or part of experimental procedures and methods, including without limit Intravenous Micronutrient Therapy, Ozone Therapy, PEMF Therapy, Prolotherapy, Prolozone, and Mesotherapy, on which no governmental (including the U.S. Food and Drug Administration (“FDA”)), scientific or medical authority has issued any guidelines or statements as tot he safety or efficacy thereof. You acknowledge that the safety record of the Treatments is based only on empirical and anecdotal evidence, which only shows that the Treatments appear to be relatively safe. We have informed you that the Treatments MAY alter, address, or decrease your pain, symptoms, or complaints, but also may have no effect.

3. **Risks, Side Effects, Complications.** We hereby inform You that there are certain unavoidable risks and potential side effects and complications to the Treatments, including without limitation infections; swelling; increased pain; bleeding; scarring; scar or wound enlargement; keloid formation; asymmetry; temporary or permanent alteration in sensation; allergic reaction; discoloration; the need for additional surgery; soreness, itching, infection, injury to nerves, internally and externally leaking fluid and scarring at injection sites (all of which except the leaking of fluid may be permanent); a feeling of “lumpiness” or permanent skin contour irregularities at the site of Treatments; spinal cord injuries, Pneumothorax (air on the outside of the lung), paralysis, dizziness, numbness, no benefit from Treatments; or other serious or debilitating injuries or death.

4. **Description of Treatments.** You acknowledge that the Treatments may involve insertion of needles into your skin and veins and the injection of standardized formulas which may include various nutritional substances, and FDA approved prescriptive medicines, local anesthetic (Procaine or Lidocaine), concentrated sugar water or dextrose, and, on occasion ozone therapy and local subcutaneous anesthetic infiltration. The exact solution and site of injection for Your Treatment, as well as the recommended sequence of Treatments, will be explained to You when We actually administer the Treatments.

5. **Health Care Staff.** You are aware that among those who attend You on Your behalf are medical, nursing, and other health care personnel in training, who unless requested otherwise, may participate in patient care as part of their education. You further consent to the presence of service representatives and/or technicians from manufacturers of equipment or devices to assist in performing and/or operation of such equipment and/or devices during operation, procedures, and Treatments. These workforce members have signed confidentiality agreements with us.

6. **Information You Provide Us.** You have provided Us with a complete list of all prescription and non-prescription medications and dietary supplements You are currently taking, and You agree to update Us periodically should this list change. You have provided us with a complete list of all known allergies You may have, and all allergic or adverse reactions You have had in the past to any medicines, dietary supplements or medical treatments of any kind. You covenant that all the information You provide Us during the course of Treatments, including without limitation the information required by this Section 6, is true, accurate, complete, and up-to-date to the best of Your knowledge.

7. **Assumption of Risk.** You hereby acknowledge that after having read carefully and understood fully the terms of this Agreement, and after having adequate time to ask any questions about this Agreement or the Treatments that you have, you are willing to assume any and all risks associated with the Treatments, including without limitation those described in this Agreement. You acknowledge that no explanation or

description of the Treatments can ever be fully explain every possible risk, side effect, or complication that may or could arise from the Treatments, but that by signing this Agreement, You nevertheless acknowledge Your willingness to assume such risks and that Your consent to the Treatment s is willing, voluntary, and informed.

8. **Alternatives.** You have been informed that there are alternatives to the Treatments including surgery, other types of injections, prescription medications and taking no action.

9. **Miscellaneous.** You agree that this Agreement constitutes the entire agreement between You and Us regarding the subject matter hereof. No promise, representation, guarantee or warranty not included in this Agreement has been or is being relied upon by You. This Agreement shall be binding on You and Your successors, heirs, legal representatives and assigns. In case any one of the previsions of this Agreement is held invalid or illegal, such provisions shall be curtailed, limited or severed only to the extent necessary to remove such illegality or invalidity. This Agreement shall be governed by the laws of the state of Hawaii without regard to any choice of the law principal. Any dispute between You and Us shall be adjudicated in state or federal court in Honolulu, Hawaii, and You submit to the jurisdiction of any such court.

Full Name

Email:

**Patient / Guardian Signature**

X

# Signature Certificate

Document name: Prolozone Consent Form

Unique Document ID: 34E4AC76AE4B9BDA09A4C63CFF5B129FE27C9EF7

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This audit trail report provides a detailed record of the online activity and events recorded for this contract.