Lakeshore Hyperbaric Center

2219 W Belmont Ave, Chicago IL 60618

773-312-4141

PATIENT CONSENT FORM

Patient Name: _____

I authorize the performance of a procedure known as Hyperbaric Oxygen Therapy to be performed under the direction of Lakeshore Hyperbaric Center.

As a patient, I give my consent to receive treatment of Hyperbaric Oxygen Therapy and have been informed of the benefits from Hyperbaric Oxygen Therapy and any possible side effects including and not limited to ear pain, sinus headache, transient problems with vision, difficulty with breathing or chest pain. I will advise Lakeshore Hyperbaric Center of any other treatments I am receiving from any other facility.

I acknowledge that the nature of this procedure has been described to me in terms which I understand and all questions I have asked have been answered to my satisfaction. Any complications or risks which may be associated with this procedure or possible alternatives have been explained.

I am aware that Lakeshore Hyperbaric Center is using hyperbaric therapy for FDA approved as well as for investigational medical conditions and I acknowledge that no guarantees have been made to me concerning the results of examination or treatments from this therapy.

I hereby agree to hold harmless Lakeshore Hyperbaric Center and any of its employees from all cost, injury and damage incurred, any of which is caused by an activity, condition or event arising out of the performance, preparation for performance or nonperformance of treatment in this facility.

_____ _____

Signature of Patient or Representative Date

If the patient is unable to sign or is a minor, complete the following:

Patient is a minor (_____) years of age, and/or is unable to sign because: