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Initial Short Office Visit

Personal History

Name: _____ Date: _____
 DOB: _____ Gender: M F
 Address: _____ City: _____ State: _____ Zip: _____
 Telephone: Home: _____ Cell: _____ Work: _____
 Email: _____

Your Doctor: _____ Phone: _____
 Date of last examination: _____ Where? _____
 How did you hear about us? _____

Allergies (food, medications, animals, etc) and type of reaction: _____

Current Medications: (Please include dosages and date started) _____

Previous Hospitalizations/Surgeries/Serious Illness: (Please include date) _____

Do you currently smoke? _____ If you have quit, when? _____

Personal History (Check all that apply)

AIDS	Breast cancer	Glaucoma	Pneumonia
Alcoholism	Bronchitis	Heart Attack	Prostate Cancer
Allergies	Cancer	Heart Trouble	Sickle Cell Anemia
Alzheimer's	Chemical dependency	High Blood Pressure	Stroke
Anemia	Colon Cancer	Irritable Bowel	Suicide Attempt
Arthritis	Depression	Kidney Disease	Tuberculosis
Asthma	Diabetes	Liver Disease	Ulcer
Birth Defects	Emphysema	Mental Illness	Other
Bleeding disorder	Epilepsy	Migraine Headaches	

Signature/Date _____



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Patient Name: _____ **DOB** _____

GENERAL CONSENT TO TREAT (Adult)

I authorize the rendering of such care, including diagnostic and therapeutic treatment by the provider as may be deemed necessary or beneficial. Treatment may include, but is not limited to, diagnostic radiology and laboratory procedures, therapeutic procedures, and administration of medications or vitamins.

I acknowledge that no guarantees have been made as to the effect of the examination or treatment of my condition. I understand that I have the right to make decisions concerning my health care, including the right to refuse medical and surgical procedures.

My signature below indicates acknowledgement that:

1. I have read and agree to all of the above.
2. I give my authorization and consent for diagnosis; and
3. I understand that I may withdraw my consent for treatment at any time.

Signature of patient: _____ **Date:** _____

Printed Name: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was given a copy of the Notice of Privacy Practices.

Signature of patient: _____ **Date:** _____

To be completed by office staff (if necessary):

Good Faith efforts were made to obtain acknowledgement of receipt of the Notice of Privacy Practices from the patient or patient's personal representative. The Good Faith efforts made and reason the acknowledgement could not be obtained were:

___ Patient refused to sign after being requested to do so.

___ Emergency situation where patient was unavailable to sign.

___ Other _____



INTRAVENOUS VITAMIN C THERAPY

BACKGROUND

The primary focus of high-dose Intravenous Vitamin C (IVC) is to treat a wide variety of chronic conditions, including cancer, or just monthly maintenance. Since humans cannot produce vitamin C, we need to consume it from food or supplement sources. One of the main challenges with taking an oral vitamin C supplement is that only a small percentage of the vitamin C (ascorbic acid) that is consumed can be absorbed by the body, and higher doses will cause gastrointestinal discomfort. The advantage of receiving vitamin C intravenously is that it bypasses the gastrointestinal system and is placed directly into circulation where the vitamin C can reach much higher concentrations, and therefore greatly increase the benefits with very few, if any, side effects.

There is an abundant amount of medical research to support the use of high-dose IVC, including research that has been done at the Riordan Clinic in Wichita, Kansas over the last 4 decades. It has been demonstrated that high doses of vitamin C are exclusively toxic to cancer cells, while leaving healthy tissue unharmed.

BENEFITS

- IVC is one of the best anti-viral agents available. It will enhance host resistance and improve the immune system's ability to neutralize bacterial, viral, and fungal infections.
- IVC can eliminate a wide range of toxins and even has a mild chelating effect for the removal of toxic heavy metals.
- In high doses, IVC has a pro-oxidant effect that results in the formation of hydrogen peroxide, which targets malignant cells while leaving normal cells unharmed.
- Vitamin C has an antihistamine effect that is useful in fighting allergies. When one lacks vitamin C, they are prone to an increase in asthma attacks and allergy symptoms.
- Vitamin C is also essential for the synthesis of collagen, the main structural protein that is found in connective tissue. This collagen stimulating effect can also assist the body to wall off malignant tumors.
- When cancer patients receive IVC they report a reduction in their pain level and that they are better able to tolerate chemotherapy. IVC is complementary to oncologic care; it is not an "either/or" proposition.
 - Patients with cancer who use IVC treatments enjoy a better quality of life. They report fewer side effects of conventional cancer treatments, faster healing, more resistance to infections, better appetite and less pain, and remain more active. They bounce back quicker because the IVC reduces the toxicity of the chemotherapy and radiation without compromising their cancer killing effects.

*For maximum benefit from Vitamin C, it is important to orally supplement with at least 4 grams of vitamin C daily. This helps to prevent a possible vitamin C "rebound effect", and helps ensure the best absorption of the IVC.

CONTRAINDICATIONS AND SIDE EFFECTS

- A very small percentage of the population has a deficiency in the enzyme known as Glucose-6-Phosphate Dehydrogenase, or G6PD, which could place the patient at risk of hemolysis (rupturing of red blood cells) with high dose IVC. A lab test to assess for G6PD deficiency will be drawn prior to any vitamin C infusion of 37.5 grams or higher.
- Some patients complain of shakiness during or soon after receiving the IVC. This is often due to blood sugar fluctuations and is relieved by eating prior to the infusion. Shakiness can also be caused by low magnesium levels. A minimum of 1mL (200 mg) of magnesium is added to all IVs to resolve this issue.
- Vitamin C infusions can cause inaccurately high results on finger-stick blood glucose readings. Glucometer readings cannot be relied upon for at least 6 hours after the completion of the IVC infusions. Standard serum glucose testing is unaffected and can be used during or following the IVC infusion if needed.
- Given the amount of fluids a patient receives during the IVC, any condition that could be adversely affected by fluid or sodium overload is in contradiction to receive IVC. Conditions that would be in question, or monitored closely, include congestive heart failure, acute renal failure, ascites, edema, etc.
- As with any IV infusion, bruising, infiltration, and pain at the site is possible.

It should be understood that high dose vitamin C therapy remains controversial in the eyes of most conventional doctors. While research has demonstrated many benefits, more research is still needed before IVC will be accepted within the usual standards of care. Therefore, at this present time, no guarantees can be made for this specialized therapy, nor can this clinic/office be held responsible for unanticipated or unexplained adverse outcomes not listed above.

POST TREATMENT INSTRUCTIONS

Patients should drink plenty of water following treatment. It may also be helpful to eat a small meal or protein-rich snack following the IV therapy to avoid fluctuations in blood sugar. Should you have any concerns following treatment, please contact us at 520-836-0666.

CONSENT

I hereby agree to the performance of Intravenous Vitamin C Therapy performed by or under the direction of the Nurse Practitioner. I understand results may vary by individual and by condition being treated and cannot be guaranteed. I have informed the provider of any contraindications that may prevent me from receiving the therapy.

_____ (Patient Name, printed)

_____ (Patient Signature) _____ (Date/Time)

_____ (Witness) _____ (Date/Time)



ESSENTIAL HEALTH AND MEDICINE

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INFORMED CONSENT FOR MEDICAL OZONE THERAPY

I, _____, state that I have been informed, understand, and accept the benefits and risks of medical ozone therapy as disclosed. Medical ozone therapy is the practice of introducing ozone into the body, and can be accomplished through several methods. Minor and Major Autohemotherapy are methods in which the patient's blood is drawn and ozone and medical oxygen are mixed with blood before it is injected back into the patient. Insufflation is a method in which ozone is blown into a body cavity, such as the rectal, vaginal, ear, or nasal cavities. Finally, a mixture of vitamins, medicine and ozone can be given as an injection into joints and/or soft tissue. The benefits of medical ozone therapy are numerous. Ozone has long been used for its antimicrobial properties, serving as a treatment for many types of infection and promoting healthy immune system function. Ozone also has anti-inflammatory properties, and has a positive effect on blood flow, circulation, and uptake and use of oxygen in the body. Finally, ozone triggers the production of antioxidants, which prevent cell damage. Diseases for which ozone may be an effective treatment include auto-immune diseases, bacterial, viral, and fungal infections, arthritis, chronic fatigue, Lyme disease, and fibromyalgia. Potential side effects of medical ozone therapy include but are not limited to weakness, slight dizziness, or sleepiness. For topical applications of ozone, there is a risk of developing a minor rash at the site of the application. Patients who have any of the following conditions should not use medical ozone therapy: G6PD deficiency or favism, Pregnancy, Thrombocytopenia, serous cardiovascular instability, bleeding disorders, ozone allergy, or patients being treated with ACE inhibitors.

Signature _____ **Date** _____

Witness _____ **Date** _____



Informed Consent Form

Photobiomodulation Intravenous or Interstitial Therapy Via Endolaser

Photobiomodulation therapy (PBMT) is a low-level laser therapies that deliver specific wavelengths and intensities of light chosen for the patient's medical needs to enhance immune function, reduce inflammation, improve microcirculation and oxygenation, increase ATP production and support for cellular energy production or other effects. Because the treatment improves many basic physiologic capacities, and the spectrum of wavelengths allow a range of benefits, this therapy has numerous applications for treatment of systemic disease including as diabetes, cardiac, liver and kidney diseases, neurodegenerative diseases, psychiatric diseases, metabolic disorders, autoimmune disease, chronic fatigue and mitochondrial syndromes; inflammation and pain, osteoarthritis, and other degenerative conditions including joint, herniated disk and other spinal conditions; local use for dermatologic conditions and many others. It has been used to treat certain cancers by complementing traditional care, directly inducing tumor death through production of reactive oxygen species within the cancer cell as well as supporting immune response. It is often used to treat acute, chronic and post Lyme/tick-borne disease or other infections.

There are a number of mechanisms by which PBMT may provide patient improvement including direct antibacterial and cleansing effects, stimulation of natural immune responses such as white cell activation, mitochondrial activation, stimulation of nitric oxide and resulting vasodilation, and venous oxygen increase. It is thought that the light stimulus induces cellular signals that affect chemical behavior, metabolism, gene expression and enzyme and protein activity.

How Intravenous or Interstitial Therapy is Done

Intravenous: During PBMT a slender fiber optic catheter is inserted in the arm intravenously via a thin, sterile butterfly needle. While blood irradiation therapy has most commonly been done by withdrawing blood, exposing it to ultraviolet radiation and reinjecting it, the endolaser instead uses a short fiberoptic catheter which can channel various intensities and wavelengths which may include ultraviolet, infrared or colors from the visible spectrum. The endolaser allows for safer and continuous treatment of a greater blood volume. The optical catheter will "irradiate" the circulating blood with the frequencies of light chosen for your condition. "Irradiation" refers only to the ultraviolet or other colored light energy; no radioactive substance is used. This procedure takes approximately one hour. The process is generally quite comfortable.

Interstitial/Needle Insertion: In order to treat joints, spinal difficulties or a specific target, such as a tumor, the laser may be inserted directly into the targeted site. A local anesthetic will be used to numb the area followed by the insertion of one or several thin cannulas depending what is being treated. This may or may not be guided by ultrasound depending on the location and nature of the treatment. A fiberoptic cable delivering the low-level laser is guided into the cannula. In some cases, a drug will be administered to enhance treatment effects.

Light Wavelengths and Their Purpose

Different wavelengths have different healing effects; you may receive more than one color of light over the course of a treatment. The wavelengths that will be used in your treatment are checked below:

- ☐ Red: Energizing effects resulting from increased ATP production; enhances immune system, increase cell activity, regenerates damaged tissue structures and improves circulation.
- ☐ Green: Increases oxygen uptake, reduces pain caused by inflammation and swelling.
- ☐ Blue: Improves microcirculation by Nitric Oxide release, strong anti-inflammatory and anti-bacterial effects, accelerates wound healing, supports pain relief, activates telomerase and biogenesis of mitochondria with maximum anti-aging effects.
- ☐ Yellow: Improvement in mood and antidepressant effects by enhancement of Vitamin D and serotonin production, positive influence on endocrine system and metabolism, stimulates the mitochondrial respiratory chain, used for chronic viral infections and its strong anti-bacterial effects.
- ☐ Ultraviolet: Directly kills bacteria and viruses and has a stimulating effect on the immune system. It has been used for a wide variety of diseases including Lyme and other infectious diseases, cardiovascular diseases, diabetes mellitus and other metabolic disorders, chronic liver and kidney diseases, macular degeneration, chronic pain syndromes, fibromyalgia and rheumatism, allergies and eczema, multiple sclerosis, depression and chronic fatigue syndrome. It has also been used in the treatment of various cancers.
- ☐ Infrared: Can be used to selectively heat cancer cells, reduce pain and inflammation.

Concurrent Use of Medications:

In addition to the laser, you will receive:

- ☐ No drugs or fluids will be injected.
- ☐ Anesthetics

Notice of FDA Status of Endolaser Treatment

While the Weberneedle® Endolaser is FDA approved for *external* use, its use internally is not recognized in the United States. Photodynamic laser therapy is provided by some physicians who practice integrative, functional, complementary or alternative medicine. Its use is controversial

and not currently approved for this route by the US Food and Drug Administration (“FDA”) or accepted by medical institutions in the United States. While internal use of the device is approved in Europe (CE Approval) and by Health Canada, the professional literature in support of the safety or effectiveness of the therapy has not been reviewed by FDA and may be considered as yet insufficient for general acceptance by the US medical community.

Potential Adverse Reactions and Contraindications

Intravenous Photodynamic Therapy

Intravenous photodynamic therapy has been widely used globally for over 30 years with few ill effects. As with any intravenous therapy, there is some risk of side effects or adverse reactions. Patients can experience discomfort, swelling and bruising at the injection/insertion site. There could be an internal reaction to the heat of the laser in very sensitive individuals. There can be a clotting of the blood in the needle, and thrombophlebitis, an inflammation of the vein may also occur and in rare cases require some treatment such as hot packs and bed rest. While sterile technique is used, any invasive medical procedure presents the rare risk of infection that can be serious or life-threatening. Any intravenous procedure carries very rare risk of a cardiovascular event, such as a coronary or pulmonary emergency that includes arterial or ventricular arrhythmias, stroke, or embolism.

As a result of the healing effects of the treatment, patients may experience a healing or “Herxheimer” reaction in which one feels “flu-like” symptoms such as aches, pains, and possibly low-grade fever as the body detoxifies from a rapid die-off of bacteria, toxins and pathogens. Patients may also experience transient hypoglycemic (low blood sugar) headache/or light-headedness, and a brief resetting of the menstrual cycle.

Interstitial/Needle Insertions Therapy

Risks and/or complications may include, but not limited to: bleeding, infection, increased pain, increased serum glucose, nerve injury, allergic reaction, menstrual irregularity or bleeding, leg edema, facial flushing, paralysis and death.

The potential risks include increased pain and allergic reaction from local anesthetics, materials containing latex, IV anesthetics and/or other medications; infection on skin or in tissue, bones, joints, discs, nerves, ligaments, possibly blood stream (Sepsis), brain and spinal cord which in extremely rare cases might require hospitalization; bleeding into the interstitial space; nerve damage, nerve injury, tissue injury, tissue damage, temporary and permanent numbness and/or weakness, paralysis, spinal cord injury, urinary and/or fecal incontinence; headache; joint injection: In addition to the above complications, injection and fluid collection in the joint(s) may require antibiotic treatment, fluid aspiration and surgical interventions.

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Possible Contraindications

The Weberneedle® Endolaser should NOT be used:

- where analgesia may mask progressive pathology, and where the practitioner would normally avoid the use of any other analgesia in order to retain the beneficial aspects of pain.
- for direct aim into the eyes of humans or animals.
- over areas injected with steroids in the past 2-3 weeks.
- over areas that are suspicious or contain potentially cancerous tissue.
- over areas of active hemorrhage.
- on patients suspected of carrying serious infectious disease and or disease where it is advisable, for general medical purposes, to suppress heat or fevers.
- over or near bone growth centers until bone growth is complete.
- over or applied to the eye.
- on ischemic tissues in individuals with vascular disease where the blood supply would be unable to follow the increase in metabolic demand and tissue necrosis might result.

Additional Precautions

Additional precaution should be used when the laser light is used on patients with the following conditions:

- Over anesthetized areas.
- On patients with hemorrhagic diathesis.
- On patients on blood thinners such as Plavix, Aspirin, Coumadin, Lovenox or Heparin and patients with prosthetic heart valves.

Additional Notices

Full Disclosure of Treatments: Patients must fully inform their treatment team of all diagnoses and all treatments that are currently, or have recently, undergone to ensure that potential drug interactions, contraindications and other concerns can be considered before beginning treatment. Patients with an implanted neurostimulation device must inform their physician before initiating therapy.

Notice to Pregnant / Breastfeeding Women: All female patients must alert their physician if they know or suspect that they are pregnant or are breastfeeding.

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No Guarantees: No practice of medicine is an exact science, there are significant individual differences between patients, and there can be no guarantees as to the outcome of treatment. No guarantees are made that I will gain any benefit or not suffer any adverse consequences.

Insurance Notice/Financial Responsibility: This treatment is not covered by insurance, Medicare or other third-party. Patients are financially responsible for payment at the time of service, even if an invoice is submitted and the payor determines that it is not a medically necessary service or is experimental. I may also be responsible for the costs of laboratory tests associated with this treatment.

Informed Consent

I authorize the treatment outlined above, acknowledge that I have read and understood this form and that my physician has discussed with me the basis for my being an appropriate patient for treatment by photodynamic laser therapy. I have discussed alternative treatment options and the risks involved, which include rare complications that may not have been specifically mentioned above. I agree that I assume the risks of this therapy and to hold [NAME PHYSICIAN AND CENTER] its physicians, principals, and staff [and researchers] associated with this study harmless for the risks of treatment [participating in this study.]

I have not been offered any guarantee as to outcome. I understand that I am responsible for payment. I represent that I am seeking treatment in order to further my own health and for no other reason. I do not represent a third party. I acknowledge receipt of a copy of this consent should I request it.

Dated:

Signature of Patient or Legal Guardian

Witness

Patient's Printed Name

Witness Name Printed