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IV Consent

This document is intended to serve as confirmation of informed consent for IV therapy.

I have informed the qualified staff members of any known allergies to drugs or other substances, or of any past reactions to anesthetics. I have informed the qualified staff members of all current medications and supplements.

I understand that I have the right to be informed of the procedure, any feasible alternative options, and the risks and benefits. Except in emergencies, procedures are not performed until I have had an opportunity to receive such information and to give my informed consent.

I understand that:

- The procedure involves inserting a needle into a vein and injecting the prescribed solution intravenously.
- Alternatives to intravenous therapy are oral supplementation and / or dietary and lifestyle changes.
- **Risks** of intravenous therapy include but not limited to:
    - Occasionally to commonly - Discomfort, bruising, pain at the site of injection.
    - Rarely - inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury.
    - Extremely Rarely - Severe allergic reaction, anaphylaxis, infection, cardiac arrest and death.
- **Benefits** of intravenous therapy include:
    - Injectables are not affected by stomach, or intestinal absorption problems.
    - Total amount of infusion is available to the tissues.
    - Nutrients are forced into cells by means of a high concentration gradient.
    - Higher doses of nutrients can be given than possible by mouth without intestinal irritation.

I understand that the following will reduce the efficacy of IV Nutrition Therapy and that it may take more treatments to reach optimal health:

- Cigarette Smoking;
- Certain medications;
- Caffeine consumption increases Vitamin C excretion;
- Poor diet: processed foods, high sugar intake, nutrient deficient diets;

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- Heavy metal toxicity;

I am aware that other unforeseeable complications could occur. I do not expect the physician(s) and or other qualified staff members to anticipate and or explain all risk and possible complications. I rely on the physician(s) and qualified staff members to exercise judgment during the course of treatment with regards to my procedure.

I understand that IV Nutrition Therapy is not covered by insurance and I understand that if I submit an insurance claim for the IV Nutrition Therapy, that I will be responsible for any and all non-covered services.

I understand the risks and benefits of the procedure and have had the opportunity to have all of my questions answered.

I understand that I have the right to consent to or refuse any proposed treatment at any time prior to its performance. My signature on this form affirms that I have given my consent to IV therapy with any different or further procedures which, in the opinion of my physician(s) and qualified staff members or other associated with this practice, may be indicated.

My signature below confirms that:

- I have read and understand the information provided in this form, had all my questions answered, are knowledgeable about the conventional treatments available for my condition, and are aware that the IV Nutrition Therapy is not FDA approved and is considered “unconventional”. Long-term adverse consequences of these therapies may be possible, but are unknown at this time.
- The provider has adequately explained the IV procedure set forth to me.
- I have received all the information and explanation I desire concerning the procedure
- I authorize and consent to the performance of the procedure as agreed upon

By signing this consent, I understand these risks, and I am willing to accept the risk. I have been advised that this therapy may be beneficial in my condition. I understand the benefits of this treatment will be enhanced by engaging in positive lifestyle changes such as exercise, proper diet, and nutritional supplementation that has been recommended by the Healthcare Provider.

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Client/Parent Signature Date