Informed Consent for Intravenous (IV) Therapy

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

(Initials) _____ I have informed the physician of any known allergies to drugs or other substances that may be included in the ingredients of my solutions, or of any past reactions to anesthetics.

(Initials) _____ I have informed the doctor of all current medications and supplements. I understand that I have the right to be informed during the procedure, 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.

The IV intravenous procedure involves inserting a needle into your vein and infusing over a determined period of time, prescribed nutrients (vitamins, minerals, amino acids).

I understand that risks, benefits and alternatives to IVs or IV/Oral chelation may include but are not limited to:
1. The Risks and potential side effects ○ Discomfort, bruising, and pain at the site of injection. ○ Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury. ○ Severe reaction, anaphylaxis, cardiac arrest, or death.
2. The Benefits ○ Injectables are not affected by stomach or intestinal disease. ○ Total amount of infusion enters the bloodstream and is available to the tissues ○ Higher doses of nutrients can be given by vein than by mouth without intestinal irritation that can accompany doses given by mouth.
3. Alternatives to intravenous vitamin therapy are oral supplementation and/or dietary and lifestyle changes.

I am aware that other unforeseeable complications could occur. I do not expectt the physician(s) to exercise judgement during the course of treatment with regards to my procedure. 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 procedure, which in the opinion of my physician(s) or other(s) associated with this practice, may be indicated.

I understand the information provided on this form and agree to the foregoing. I understand that there is no implied or stated guarantee of success or effectiveness of any treatment. The procedures) set forth above has been adequately explained to me by my physician. I understand that I am free to withdraw my consent and to discontinue participation in their treatments at any time. I understand that, except in emergencies, I must give 24 hours notice of intent to cancel or reschedule my appointment.

I understand that I will incur the full fee for treatment, regardless of amount used due to wasted materials.

My signature below confirms that:

1. I have received all the information and explanation I desire concerning the procedure.

2. I authorize and consent to the performance of the procedure(s)

Date: _____

Patient Name: _____

Patient Signature: _____

If signed by representative, indicate relationship: _____ Patient/Representative

Signature: _____