WELLNESS MEDICAL CENTER LLC.

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Informed Consent for Intravenous (IV) Infusion Therapy

I, ___________________________________, DOB _____/_____/_____, hereby authorize the following procedure: **Administration of Intravenous Vitamins, Minerals, and other Nutrients.**

This procedure is recommended for the replacement of these essential nutrients, correction of deficiencies, and for other therapeutic effects, such as improving immune function, improving antioxidant status, reducing oxidative damage, improving fatigue, boosting muscle recovery and energy, and possibly improving cellular function and repair to slow aging.

(Initials)_____ I have informed the physician of any known allergies to medications or other substances and of all current medications and supplements. I have fully informed the nurse and/or physician of my medical history.

(Initials)_____ Intravenous infusion therapy and any claims made about these infusions have not been evaluated by the US Food and Drug Administration (FDA) and are not intended to diagnose, treat, cure or prevent any medical disease. These IV infusions are not a substitute for your routine primary medical care.

(Initials)_____ 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 the opportunity to receive such information and to give my informed consent.

(Initials)_____ I understand that:

1. The procedure involves inserting a needle into a vein and injecting the prescribed solution.
2. Alternatives to IV therapy are oral supplementation and/or dietary and lifestyle changes.
3. **Risks of IV therapy** include but are not limited to: a) *Occasionally*: Discomfort, bruising, and pain at the site of injection. b) *Rarely*: Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury. c) *Extremely Rare*: Severe allergic reaction, anaphylaxis, infection, cardiac arrest, and death.

4. **Benefits of IV therapy** include a) Injectables that are not affected by the stomach acid or intestinal absorption problems. b) Total amount of infusion is available to the tissues, meaning it is 100% absorbed. c) Nutrients are forced into cells by means of a high concentration gradient. d) Higher doses of nutrients can be given than possible by mouth and without intestinal irritation.

(Initials)_____ I am aware that other unforeseeable complications could occur. I do not expect the nurse or physician to anticipate and or explain all the risks and possible complications. I rely on the nurse and physician to exercise judgment during the course of treatment with regard to my procedure. I understand the risks and benefits of the procedure and have had the opportunity to have all of my questions answered.

(Initials)_____ 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 infusion Therapy, including any other procedures which, in the opinion of my physician or others associated with this practice, may be indicated.

This procedure may be considered medically unnecessary. It may or may not mitigate, alleviate, or cure the condition for which it has been prescribed. This therapy has been recommended to you in the belief that it is of potential benefit in these circumstances and its use will quite probably improve the condition for which you are under treatment and in your overall health.

Based on the risks and potential benefits of the current medically indicated treatment(s) and of this proposed treatment, I have elected to receive this proposed treatment from Dr. Olena Gordon, MD, and other health professionals at ***Wellness Medical Center*** as is appropriate and necessary for my health care.

I further understand and agree to adhere to the treatment schedule and attend the follow-up visitations set by my medical provider to permit observation and the study of my progress. I understand that I may suspend or terminate my treatment at any time by informing my medical provider. I assume full liability for any adverse effects that may result from the *non-negligent* administration of the proposed treatment. I waive any claim in law or equity for a redress of any grievance that I may have concerning or resulting from the procedure, except as that claim pertains to *negligent* administration of this procedure. The risks involved and the possibilities of complications have been explained to me. I fully understand and confirm that the nature and purpose of the aforementioned treatment to be provided may be considered unproven by scientific testing and peer-reviewed publications and therefore may be considered medically unnecessary or not currently indicated.

I hereby place myself under your care for **IV Vitamin Therapy.** I also verify that all information presented to the medical provider in my medical history is true to the best of my knowledge. I am not misrepresenting myself and I place myself under your care for the sole purpose of treatment for these conditions.

I hereby acknowledge that I understand that my insurance coverage, including Medicare, may not pay for this non-covered service, and that all services ancillary to this treatment may be also non-covered services and non-reimbursable. I agree to be responsible for payment at the time of service for all non-covered services.

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Patient Full Name

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Date

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Patient Signature

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Nurse Full Name

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Date

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Nurse Signature