IV Therapy Consent Form

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

This procedure is intended to *Replenish, Recover and Renew* the client. Treatment focuses on replacement of essential nutrients and correction of deficiencies, but also can provide other therapeutic effects such as improving immune function, improving antioxidant status, reducing oxidative damage, improving fatigue, boosting energy, boosting muscle recovery, and improving cellular function and repair.

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

(Initials)_____ Intravenous infusion therapy and claims made about these infusions have not been evaluated by the US Food and Drug Administration (FDA). They 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:

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 injection site; b) rarely: inflammation or infection of the vein/injection site, metabolic disturbances; c) extremely rare: severe allergic reaction, anaphylaxis, and nerve damage.
4. Benefits of IV therapy include: a) treatment/nutrient delivery that is not affected by the stomach acid/intestinal absorption problems; b) 100% absorption of treatment; total amount of infusion available to the tissues; c) nutrients are quickly absorbed and available for immediate cellular use due to high concentration gradient; d) higher/more potent 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 provider to anticipate and or explain all the risk and possible complications. I expect the provider to exercise judgement during treatment with regards to my procedure. I understand the risks and benefits of the procedure and have had the opportunity to have all 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 IV903 for infusion therapy.

Date: ____/____/____
Printed Name: _____
Signature: _____