Consent for IV Therapy

I, _____ DOB ___/___/___ , hereby authorize the following procedure: administration of intravenous vitamins, minerals, and other nutrients.

This procedure is recommended for replacement of these essential nutrients, correction of deficiencies, and for other therapeutic effects, such as improving immune function, improving antioxidant status, reducing oxidative damage, decreasing bronchospasm, improving fatigue, etc.

The principal side effects that may accompany intravenous administration of nutrients include:
-burning and stinging at the site of infusion or if IV infiltrates into surrounding tissue
-muscular spasms, weakness, or fatigue
-allergic reactions (rare)
-local thrombophlebitis (very rare).

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.

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 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 hereby place myself under your care for intravenous vitamin therapy, and agree to the above release. I also verify that all information presented to 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 may not pay for this service. I agree to be responsible for payment at the time of service for all services, including Non-covered services.

_____ **DOB** ___/___/____
Print Patient Name

_____ _____
PATIENT SIGNATURE DATE

_____ _____
Witness DATE

_____ _____
Medical Provider DATE

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