(INSERT CLINIC NAME, LOGO, PHONE NUMBER, ADDRESS)

IV Infusion and Injection Consent Form

This form outlines that you understand that a peripheral intravenous catheter will be inserted into a vein in your body, and you will have fluids, vitamins, minerals, nutrient, and/or medications infused directly into your body. This is considered “IV Infusion Therapy.” If you are having injection therapy, then you understand that a vitamin, mineral, nutritional compound, and/or medication will be injected directly into the subcutaneous fat or muscle of your body. This is considered “Injection Therapy.”

Please initial each point bellowing acknowledging that:

_____ I understand that IV infusion and injection therapy at (INSERT CLINIC NAME) is not intended to diagnose or treat a specific medical condition.

_____ I understand that IV infusion and injection therapy will not prevent, treat, or cure and medical condition or disease. Furthermore, I understand that I am here seeking IV infusion and/or injection therapy voluntarily to assist with certain symptoms or ailments I may be experience.

_____ I have informed (Insert clinic name, your name, nurses name) of all the medications, supplements, and allergies that I have. I understand that serious adverse events could happen if I do not disclose all of my drug/food/vitamin/and additional allergies and medications/supplements that I am currently taking.

_____ I understand that IV and injectable therapy and any claims made about these treatments 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. I understand that these treatments are not FDA approved for any given indications of treatment and are not considered a medical necessity.

_____ I understand that I have been informed of the procedure involving IV infusion and injections, the alternative treatment options, and the risks and benefits of the mutually agreed upon treatment.

_____ I understand that the procedure involves inserting a needle into a vein or having a solution injected into my muscle or body fat.

_____ I understand that common risks involved with IV and injection therapies include, but are not limited to, irritation, pain, discomfort, bruising, and bleeding at the site of the IV insertion or injection.

_____ I understand that less common risks involved with IV and injection therapies include, but are not limited to, infection at the site of the IV insertion or injection, injury to the tissue, phlebitis, low blood pressure, fainting, fluid volume overload, medication interactions, and drops in blood sugar levels.

_____ I understand that rare side risks involved with IV and injection therapies include, but are not limited to, sepsis, severe allergic reactions, severe medication/supplement interactions, anaphylaxis, blood clots, shock, cardiac arrest, and death.

_____ I understand that the benefits of IV and injection therapies include, but are not limited to, enhanced absorption of vitamins and minerals as they bypass the digestive tract, increased total body hydration, alleviation of certain symptoms, increased total body nutrient density, and improved performance/recovery.

(INSERT CLINIC NAME, LOGO, PHONE NUMBER, ADDRESS)

_____ I affirm that I am voluntarily seeking IV infusion and injection therapies at (INSERT CLINIC NAME) and have not been coerced into doing so.

_____ I understand the risks and benefits of the procedure, IV infusion therapy, and injection therapy and have had all my questions answered to my full satisfaction.

_____ I understand that unforeseeable complications can arise when an IV is placed and medications/fluids/minerals/vitamins are infused into the body.

_____ I understand that I have the right refuse any treatments or treatment recommendations at any time.

Voluntary Nature of Treatment and Alternative Therapies

Treatment with IV and injectable vitamins/hydration/nutritional/mineral and/or medications offered at (INSERT CLINIC NAME) is completely voluntary in nature. Alternative therapy for the symptoms you are seeking IV infusion and injectable therapy for include, not are not limited to, ongoing treatment by your primary care provider and/or specialty provider, oral supplementation, and dietary/lifestyle modifications.

I acknowledge that IV infusion and injection therapy provided at (INSERT CLINIC NAME) is voluntary in nature and that I am seeking out this therapy on my own or from the recommendation of my referring provider. I acknowledge that I have also notified my medical and/or mental health provider about my decision to undergo IV and injectable vitamin/hydration/nutritional/mineral therapy. I acknowledge the alternative treatment options and have voluntarily decided to pursue IV and injectable therapy.

Signature _____ Date_____

Final patient consent for treatment.

- I have had the nature of the procedure and/or treatment, the benefits of treatment, the risks of treatment, the side effects, the alternative therapies for my medical condition or symptoms I am seeking treatment for, and the chances of treatment success explained to me. I have had all my questions and concerns answered to my satisfaction. I acknowledge that I have been given sufficient information about IV hydration/vitamin/mineral/nutrient infusion and injection therapy and all its associated risks and benefits upon which to make an informed decision about treatment.
- I acknowledge that there are no guarantees regarding the results of treatment and its effect on my presenting condition.
- I give my consent for the use of emergency intervention if required during treatment.
- I certify that I am of sound mind and body to make medical decisions and to consent for treatment.
- I certify I will continue to remain under the care a licensed and qualified primary care provider and/or mental health provider as IV infusion and injection therapy is considered an adjunctive and non-medically necessary treatment option, not a complete one.

(INSERT CLINIC NAME, LOGO, PHONE NUMBER, ADDRESS)

- I release (INSERT PROVIDER NAME) at (INSERT CLINIC NAME) and all the medical staff from all liabilities for any complications or damages associated with IV infusion and injection therapy.
- I have read this consent and fully understand the information within it and I voluntarily authorize and consent to the treatment options, including but not limited to IV infusion therapy, provided to me at (INSERT CLINIC NAME).

Signature _____ Date_____