



LANDER HOPE CLINIC

Wellness Medical History Form *(Please Print)*

Name:		Date:
Address:		Date of Birth:
City/State:		Zip:
Primary Phone:		Primary Email:
Emergency Contact <i>(Name & Number)</i> :		
Referred by:	How did you hear about us?	

Allergies (Medication / Food Allergies/ Vitamin Allergies):

Current Medications: (Medicines, herbs, supplements, vitamins, etc.)

Heart Condition: YES NO _____ High Blood Pressure: YES NO _____

GI/Gastroenterology YES NO _____ Kidney Condition: YES NO _____

Musculoskeletal: YES NO _____ Endocrine: YES NO _____

Pregnant: YES NO _____ Could you be pregnant? _____

Lung Condition: YES NO _____ Hepatic: YES. NO. _____

Anemia or other Blood Disorder YES NO _____

Methylation Issues to your knowledge? YES NO _____

Do you have a sulfur allergy? YES NO _____

Any change in medical history since last visit: _____

Lander Hope Clinic Intravenous/Injection Therapy Consent

This document is intended to serve as confirmation of informed consent for intravenous (IV) and Intramuscular (IM) therapy as overseen by the medical director at Lander Hope Clinic.

(Initials) _____ I have informed the medical practitioner of all current medications and supplements as well as any pre-existing medical conditions.

(Initials) _____ I have informed the medical practitioner of any known drug allergies, or of any past reactions to anesthetics/intravenous therapy.

(Initials) _____ I understand that I have the right to be informed of the procedure, any feasible alternative options, and the risks and benefits of IV therapy.

(Initials) _____ Because of the open setting of Lander Hope Clinic, personal medical information relating to the procedure, and type of IV drip may be discussed amongst other patients. If you would like a more private setting to discuss information such as, but not limited to, past medical history, current vitals, or medication information please indicate below and we would be happy to accommodate your request.

I would like a private consultation

1. Benefits of intravenous therapy:

- IV therapy is not affected by, stomach or intestinal disease/malabsorption.
- Full amount of IV infusion enters the bloodstream for availability to tissues.
- Higher doses of nutrients can be given intravenously without intestinal irritation that can accompany doses given orally.

2) Risks and potential side effects of intravenous therapy:

- 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.

3. Alternatives to IV vitamin therapy:

- Oral supplementation
- Dietary and lifestyle changes

I understand that I have the right to consent to or refuse any treatment at any time prior to its administration. My signature on this form affirms that I have given my consent to intravenous/intramuscular therapy and I am aware that other unforeseen complications can occur. Therefore, I give my consent to Lander Hope Clinic using the Emergency Protocol should it be deemed necessary by the Medical practitioner. If the Emergency Protocol is not effective for the client, Lander Hope Clinic medical practitioner's reserve the right to call 911.

I will hold LANDER HOPE CLINIC, it's owner(s), agents, employees and shareholders completely harmless from all and any litigation or claims made should I have an adverse reaction to treatment.

I understand that if I am currently, or was recently, under the influence of drugs and/or alcohol that Lander Hope Clinic is not responsible for any adverse effects or interactions as a result of receiving IV Vitamin Therapy.

I understand the risks and benefits of the procedure and have had the opportunity to have all my questions answered by Lander Hope Clinic medical staff.

I understand that there is no implied or stated guarantee of success or effectiveness of any treatment offered by Lander Hope Clinic. I understand that Lander Hope Clinic is not treating or diagnosing any condition. I understand that I am free to withdraw my consent and to discontinue participation in treatment at any time. I understand that I will incur the full fee for treatment regardless of the amount used.

I understand that I am consenting to an automatic blood draw and blood testing in the event of any accidental bloodborne or bodily fluid exposure to any Lander Hope Clinic staff member.



LANDER HOPE CLINIC

IV Infusion and Injection Informed 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 Lander Hope Clinic 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 Lander Hope Clinic staff 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.

_____ I affirm that I am voluntarily seeking IV infusion and injection therapies at Lander Hope Clinic 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.

_____ I agree that if I am having any side effects or become sick, that I will follow up with my primary care provider or go to an urgent care or emergency department.

_____ I acknowledge that Lander Hope Clinic and Janeen Beard may not be my primary care provider. I agree that I will continue with routine care through my primary care provider and notify them of treatments prescribed and performed at Lander Hope Clinic.

_____ I understand that there are no refunds for services or products rendered.

_____ I understand that after every 4 infusions, I must have required blood work before a 5th infusion.

_____ I understand that having an appointment with Lander Hope Clinic does not necessarily entitle me to having an IV infusion or injection procedure performed. Every individual is different, and it is at the medical providers discretion to issue treatment.

_____ I understand that I must maintain my follow up appointments and following post procedural care instructions to remain on treatment. It is important that Janeen Beard, FNP-C and Lander Hope Clinic manages my treatment and it is at their discretion to provide me ongoing therapies if desired.

_____ I acknowledge that I have been advised of the risks and benefits of treatment. I also acknowledge that I have been advised of possible complications and side effects. I understand the risks, benefits, complications, and side effects of treatment.

_____ I am voluntarily requesting treatment with Lander Hope Clinic and Janeen Beard, FNP-Cin regard to IV infusion therapy and injection therapy as determined by a mutual decision between myself and the medical provider even if it is not considered a medical necessity.

_____ I do not hold any medical practitioner of Lander Hope Clinic responsible for performing age-related preventive care. I agree that I will follow up with my primary care provider to obtain these screenings and I hold Lander Hope Clinic and Janeen Beard harmless if an adverse event occurs during my treatment.

Voluntary Nature of Treatment and Alternative Therapies

_____ Treatment with IV and injectable vitamins/hydration/nutritional/mineral and/or medications offered at Lander Hope Clinic 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 Lander Hope Clinic 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.

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.
- I release Janeen Beard, FNP-C at Lander Hope Clinic 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 Lander Hope Clinic

I, _____, agree to indemnify, defend, protect, and hold harmless the medical providers employed by Lander Hope Clinic, Inc. and their respective officers, directors, employees, stockholders, assigns, successors and affiliates (Indemnified Parties) from, against and in respect of all liabilities, losses, claims, damages, judgements, settlement payments, deficiencies, penalties, fines, interest and costs, expenses suffered, sustained, incurred or paid by the indemnified parties, in connection with, results from or arising out of, directly or indirectly, the medical providers employed by Lander Hope Clinic, Inc.; rendering medical care, services, advice, and/or treatment, my failure to disclose all relevant information regarding my medical and physical condition, acts or omissions, the medical providers employed by Lander Hope Clinic, Inc.; harm or injury resulting from medical care or pharmaceuticals provided directly or indirectly by the medical providers employed by Lander Hope Clinic, Inc.. I am aware of the potential side effects associated with IV infusion and injectable therapies provided by Lander Hope Clinic, Inc., accept all the risks involved with IV infusion and injectable therapies, and will not seek indemnification or damages from the indemnified parties.

Printed

Name: _____

Signature: _____ Date: _____

LHC Staff: _____ Date: _____