Ruth & Honey Co

The village you've been waiting for.

IV THERAPY INTAKE & CONSENT AGREEMENT

This IV Therapy Intake & Consent Agreement (the "Agreement") is entered into on the date signed (the "Effective Date"), by and between:

Agency: Ruth and Honey Co. (Hereinafter referred to as "Agency")

Mailing Address:

929 N. Val Vista Dr., Ste. 109 #1193

Gilbert, AZ 85234

Phone: (833)-274-6249

Client/Patient/Authorized Representative: (Hereinafter referred to as "Client")

Patient Name: _____

Address: _____

Phone: _____

Representative Name (if applicable): _____

Relationship (if Representative): _____

This form is intended to provide you with an overview of your treatment to explain the risks and possible side effects of such treatment, to collect a medical history from you to ensure that treatment is appropriate, and to obtain your consent for treatment. Please read through this form in its entirety and complete it to the best of your knowledge before receiving any treatment. If you have any questions regarding the information in this form, please consult your infusion nurse or physician before receiving treatment. This form ***MUST*** *be completed* ***before*** *labor begins.*

MEDICAL QUESTIONNAIRE

What is your primary reason for seeking IV therapy?

- Fatigue/Low Energy
- Trouble Concentrating
- Sports or Activity Recovery
- Poor Diet/Dehydration
- Weight Issues
- Stress
- Depression/Anxiety
- Hangover
- Headaches
- Asthma/Allergies
- Cold/Flu Symptoms
- Recent Illness
- Antibiotic Infusion (w/provider order)
- Muscle Pain or Spasms
- Joint/Mobility Issues
- Digestive Issues
- Other: _____
  - _____
  - _____

Do you currently have or have you had a history of any of the following (circle yes or no):

Abnormal Bloodwork	Yes	/	No
Allergies	Yes	/	No
Asthma	Yes	/	No
Bleeding Disorder	Yes	/	No
Cancer	Yes	/	No
Current Infection	Yes	/	No
Diabetes	Yes	/	No
Electrolyte Imbalance	Yes	/	No
Extremity Swelling	Yes	/	No
G6PD Deficiency	Yes	/	No
Heart Disease / Heart Attack	Yes	/	No
Hepatitis	Yes	/	No
High Blood Pressure	Yes	/	No
HIV/AIDS	Yes	/	No
Hormone Imbalance	Yes	/	No
Kidney Problems	Yes	/	No
Leber's Disease	Yes	/	No
Liver Disease	Yes	/	No
Seizure Disorder	Yes	/	No
Sickle Cell Anemia	Yes	/	No
Stroke	Yes	/	No
Thyroid Disorder	Yes	/	No
Vitamin Deficiency	Yes	/	No

If you answered yes to any of the above, please describe:

_____

_____

_____

Please list all medications (prescription, over the counter, vitamins, herbs, and supplements) you are currently using:

Medication/Supplement Name	Dosage	Frequency	Date Started

Additional Medications:

_____

_____

_____

Please list any allergies you have to medication, food, materials, or metals:

_____

_____

_____

Please list any prior surgeries or hospitalizations you have had and the dates:

_____

_____

_____

Please answer the following questions:

1. Are you currently pregnant or breastfeeding? Yes / No
2. Do you smoke? Yes / No
   If yes, how often: _____
   _____
3. Do you drink alcohol? Yes / No
   If yes, how many drinks per week? _____
   _____
4. Do you use recreational drugs: Yes / No
   If yes, which drugs and how often? _____
   _____

Please describe any other health history or concerns that you have that have not been addressed above:

_____
_____
_____
_____
_____

ABOUT THE PROCEDURE

Potential Risks

Potential risks of IV therapy may include, but are not limited to: mild to moderate discomfort, pain, bruising at injection site, infection at injection site, damage to blood vessels, swelling at or around injection site, inflammation of veins, dizziness or fainting, changes in blood pressure or blood sugar during or after treatment, fluid overload, electrolyte imbalance, bleeding, allergic reaction, skin necrosis, warming or burning sensation at the site of injection, thrombophlebitis or venous thrombosis, air embolism, general malaise or fatigue post treatment, fever, nausea, and in extremely rare cases, anaphylaxis, cardiac arrest, or death.

Contraindications

Individuals with these contraindications **MUST** consult their healthcare provider before undergoing IV therapy to ensure safe and appropriate treatment options.

- Have severe dehydration requiring immediate medical attention.
- Are allergic to components commonly used in IV solutions (*please let your nurse know of any allergies you have before the procedure)
- Have any medical condition that may be made worse by IV therapy, including, but not limited to, congestive heart failure, severe kidney disease, or electrolyte imbalances
- Have a known blood clotting disorder or a history of thrombosis
- Have untreated or uncontrolled hypertension (high blood pressure)
- Have heart failure or severe cardiac disease
- Have liver disease or liver failure
- Are pregnant or breastfeeding
- Have an active infection
- Have undergone recent surgery or trauma involving the veins or circulatory system
- Have any other significant medical condition

_____ I attest that I have consulted my provider before requesting infusion services. I understand that elective IV therapy under the following conditions may present complications, and I have discussed potential adverse events with my provider.

Alternative Treatments

Elective IV therapy is strictly voluntary. The treatment is not necessary or required. Alternative treatments include avoiding the IV infusion procedure, taking oral antibiotics as prescribed by your provider, oral supplementation, and/or dietary and lifestyle modifications. If deemed medically necessary, proper documentation from your provider is required before receiving IV infusion therapy. For alternative treatments to medically necessary infusions, please consult with your referring provider.

Post Treatment

After your treatment is complete, you should:

1. Apply pressure to the IV site for at least two minutes after the IV is removed.
2. Keep the bandage in place for 30-60 minutes. It may be necessary to keep it in place longer if you are using blood thinners or have a blood-clotting disorder.
3. You may use warm packs and elevate your arm to reduce discomfort and promote healing.
4. You may use cold packs for pain relief and to reduce swelling.
5. Stay hydrated by continuing to drink water.
6. Contact your primary care provider or the agency if you experience any concerning symptoms. If symptoms worsen post-treatment, including significant swelling, increasing redness over the vein, persistent vein/arm pain, or headaches that are unresponsive to hydration or over-the-counter pain relievers, contact your referring provider or visit your nearest emergency room.
7. If you experience life-threatening symptoms or an emergency, call 911 immediately.

Results

Elective IV therapy may yield a range of outcomes. One primary outcome is enhanced hydration, which supports increased energy, mental clarity, and overall well-being. IV therapy also delivers antibiotics, essential vitamins, minerals, and antioxidants directly into the bloodstream, promoting optimal serum levels of the treatment to support various bodily functions and to treat/prevent infections. Infusions of nutrients or vitamins can result in increased energy levels, improved mood, and enhanced cognitive function. IV therapy may also help with detoxification by flushing out toxins and waste products from the body and contributing to a feeling of revitalization. Medically necessary treatments will yield a variety of results and should be discussed with your referring provider.

Most patients feel better immediately after treatment. However, some patients may temporarily feel tired or unwell due to the detox process.

It is important to note that while many individuals experience positive effects from IV therapy, results are not guaranteed and can vary depending on factors such as lifestyle, diet, and overall health status. For some people, achieving desired outcomes may require multiple treatments to sustain the benefits over time. Therefore, regular sessions of IV therapy may be recommended as part of a holistic approach to maintaining health and wellness. Consulting a healthcare provider can help determine the most appropriate treatment plan to optimize outcomes based on individual needs and goals.

Cost

IV infusion services are not reimbursable by government or private health insurance providers. The cost of IV therapy is **$300,** and patients must pay a 75% deposit at the time of booking.

Prenatal IV therapy:

IV therapy procedures require payment before service. A 75% deposit is due following the consultation and must be paid before providers are on call for services. All remaining funds are due before 37 weeks' gestation. Consults completed after 37 weeks of gestation require payment immediately following the consultation to ensure providers are available for on-call services.

General IV therapy:

Elective services are not reimbursable by government or private health insurance providers. Clients are required to pay a 75% deposit upon booking. All associated fees and outstanding balances are due before the scheduled appointment time.

Refunds

Perinatal IV Antibiotic Infusions:

There are no refunds for these services. The Honest Mama Project dba Ruth & Honey Co. is on call when services are requested and remains on call until they are provided or attempted. This policy ensures that Ruth and Honey Co. can secure on-call staff and stay on call until birth. IV antibiotic services provided during labor involve advanced coordination, on-call staffing, medication preparation, and time-sensitive clinical readiness.

Due to the nature of this service, **refunds will not be issued.** This includes but is not limited to the following reasons or requests:

- Labor progressing faster or slower than anticipated
- The client presenting too late in labor to complete the recommended dosing
- Change in birth plan or delivery location
- Provider recommendation to delay, stop, or modify antibiotic administration based on clinical assessment
- Hospital, birth center, or provider refusal or inability to allow continuation of the infusion
- Transfer of care or emergency medical interventions that interrupt treatment
- Partial completion of antibiotics due to labor progression or delivery
- Clients seeking services for ruptured membranes or prolonged rupture of membranes only
- Missed birth due to the agency being unaware of labor
- Missed birth due to the agency's inability to make it to the client as a result of insufficient time notification.
- Delayed communication from the client, representative, or care team
- Clients seeking services following the 37-week gestation timeframe

General IV Infusion Services (Non-Labor)

Refunds for general IV infusion services may be issued **only if services have not begun** and cancellation occurs within the outlined timeframe. In this case, refunds are at the agency's discretion and may be limited to partial reimbursement.

Refunds **will not be issued** in the following circumstances:

- Client cancellation or rescheduling with less than 72-hour notice
- Client no-show at the scheduled appointment time
- Inability to establish IV access after reasonable attempts
- Client discomfort, intolerance, or decision to discontinue the infusion after initiation
- Provider determination that proceeding with infusion is not clinically appropriate or safe
- Failure to disclose relevant medical history, medications, or contraindications before service
- Partial completion of an infusion for any reason

Once on-call availability has been secured and/or services have been initiated, the fee reflects **clinical readiness, time reserved, and professional availability**, not solely the completion of all doses. Once IV access is established or supplies are opened, services are considered initiated, and **no refunds will be provided**.

Refunds Initiated by the Agency

Refunds may be issued at the discretion of Ruth & Honey Co. when services cannot be provided due to circumstances **directly attributable to the agency**. These may include, but are not limited to:

- Inability to establish IV access after reasonable and clinically appropriate attempts
- Agency staff unavailability due to unforeseen emergencies or illness
- Missed attendance at a scheduled perinatal or labor-related service due to extenuating circumstances on the part of the agency
- Medication preparation or delivery errors identified before administration

- Determination that proceeding with the infusion is not clinically appropriate due to agency-identified safety concerns before initiation
- Scheduling errors made by the agency resulting in the service not being performed

Refunds, when issued, may vary and will not exceed 50% of the service fee. Refunds in these instances depend on the extent of services rendered, time reserved, and resources utilized.

IV Discontinuation (DC) Policy

If Ruth & Honey Co. is unavailable to discontinue (DC) the IV for any reason, the IV may be safely discontinued by the attending midwife, nurse, physician, or other qualified healthcare provider on site. The client understands and agrees that IV discontinuation does not require the original administering clinician, provided it is performed by a licensed healthcare professional acting within their scope of practice. Ruth & Honey Co. is not responsible for delays or outcomes related to IV discontinuation performed by another provider.

Informed Consent

Please initial next to each statement:

_____ I consent and authorize the administration of IV infusion therapy.

_____ I have received, reviewed, and understand this Intake and Consent Form and have had the opportunity to ask questions.

_____ I have informed the nurse or physician of any known allergies to medications or other substances.

_____ I certify that I have read, or have had read to me, the contents of this Intake and Consent Form.

_____ I understand the risks and potential complications associated with IV therapy procedures and understand that results cannot be guaranteed.

_____ I understand that if any signs of allergic reaction or anaphylaxis occur, the infusion will be discontinued, and that the recommendation is to report to the emergency department immediately for higher-level care.

_____ I understand that getting an IV therapy infusion while pregnant comes with risks. I have reviewed those risks with my prescribing provider and would like to proceed with IV therapy.

_____ I understand that I may need to have labs drawn before or after my infusion.

_____ I consent to having laboratory tests drawn before or after the infusion session, either from the IV site or from a separate venous site.

_____ I understand that laboratory specimens will be delivered to the appropriate laboratory location, and results will be sent to my provider.

_____ I understand that obtaining an IV may require more than one attempt with an IV needle. I also understand that if the administering provider cannot place an IV after three attempts, another provider may be called to do so.

_____ I understand that extravasation, infiltration, blown blood vessels, bruising, or pain may result from venipuncture.

_____ I understand that if an IV cannot be placed, I will need to follow up with my provider for medication, labs, and vitamin/mineral recommendations or report to the hospital for a higher level of care.

_____ I release the provider(s) administering IV therapy from all liability related to complications, fetal harm, distress, and death, and understand that the provider is only administering fluids and medications ordered at the prescribed dosage, rate, route, frequency, and time indicated by my provider.

_____ I understand that IV therapy is an elective procedure, and alternative treatment options have been explained to me.

_____ I have been provided with and understand the aftercare instructions, and I am aware that failure to follow them may result in unsatisfactory outcomes and potential complications.

_____ If I experience pain or discomfort during the procedure, I will immediately inform the nurse or physician.

_____ I understand that the nurse or physician reserves the right to refuse to perform treatments on anyone whom s/he deems to have a condition for which IV therapy is contraindicated.

_____ I am over 18 years of age.

_____ I am not under the influence of alcohol or drugs.

_____ I was educated on the side effects of antibiotics, signs and symptoms of an allergic reaction, and had all of my questions related to antibiotic infusions answered.

_____ I understand that I will receive _____ IV infusion as ordered by my provider.

_____ I have completed a consultation **or** have waived the right to consult before services.

Informed Consent (cont.)

I, _____ (*print name*), certify that the information provided in this form is accurate and correct to the best of my knowledge. I have read and understand this form in its entirety. I voluntarily consent to treatment.

Patient Signature: _____

Patient Printed Name: _____

Date: _____

POA/Representative Signature: _____

POA/Representative Printed Name: _____

Relation to client: _____

Date: _____

Photo/Video Consent

We may take photographs and/or videos of you to document today's treatment. You may choose whether you want to allow us to share the pictures and/or videos for advertising, educational, and marketing purposes by initialing below (*please initial one*):

_____ ***NO*** Patient does not agree to the release of the photos. We will keep your images confidential and will not disclose them to any third party.

_____ ***YES*** Patient agrees to the following photo release:

Patient agrees that The Honest Mama Project dba Ruth and Honey Co. has the right to use and publish photographs and/or videos. I further grant permission to use the image(s) or likeness in any form of media for commercial purposes, advertising, trade, or personal use.