

INTRAVENOUS (IV) THERAPY CONSENT FORM



This procedure is recommended for replacement of these essential nutrients, correction of deficiencies, and for other therapeutic effects, such as hydration, 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 fully understand and confirm that the nature and purpose of the treatment to be provided may be considered unproven by scientific testing and peer-reviewed publications and therefore may be considered medically unnecessary or not currently indicated.

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, including Medicare, may not pay for this non-covered service, and that all services ancillary to this treatment may be also non-covered services and non-reimbursable. I agree to be responsible for payment at the time of service for all services, including non-covered services.

ACKNOWLEDGEMENT AND CONSENT TO CARE

By signing below, I authorize Taylor Health to provide such care. Parent/Guardian signature required if patient is under 18 years of age.

Patient Name (Print)

Patient Signature

Date

Parent/Guardian Name (Print)

Parent/Guardian Signature

Date