BODY & MIND WELLNESS CENTER
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Intravenous (IV) Infusion Therapy Consent Form

This document is intended to serve as informed consent for your Intravenous (IV) Infusion Therapy.
(Initials)_____ I have informed the healthcare practitioner of any known allergies to medications or other substances and of all current medications and supplements. I have fully informed the healthcare practitioner of my medical history.
(Initials)_____ Intravenous infusion therapy and any claims made about these infusions 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. These IV infusions are not a substitute for your physician's medical care.
(Initials)_____ I understand that I have the right to be informed of the procedure, any feasible alternative options, and the risks and benefits. Except in emergencies, procedures are not performed until I have had an opportunity to receive such information and to give my informed consent.
(Initials)_____ I understand that before IV Infusion Therapy, I need to:

1. Complete blood work (CBC, Comprehensive Metabolic Panel, G6PD, Ceruloplasmin, U/S)
2. Arrive hydrated – if dehydration occurs due to the IV, you will be given fluids to correct the dehydration.
3. Arrive having eaten a meal or brought snacks with you

(Initials)_____ I understand that the following will reduce the efficacy of IV Infusion Therapy and that it may take more treatments to reach optimal health:

1. Cigarette smoking
2. Caffeine consumptions (increases vitamin C excretion)
3. Poor diet: processed foods, high sugar intake, nutrient deficient diets
4. Heavy metal toxicity

(Initials)_____ I understand that:

1. The procedure involves inserting a needle into a vein and injecting the prescribed solution.
2. Alternatives to intravenous therapy are oral supplementation and/or dietary and lifestyle changes.
3. Risks of intravenous therapy include, but are not limited to:
    a. Occasionally: Discomfort, bruising and pain at the site of injection, a fall in blood pressure (staff will stop the infusion and provide IV fluids to help it return to normal).
    b. Rarely: Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury.
    c. Extremely Rare: Severe allergic reaction, anaphylaxis, infection, cardiac arrest, and death.
    d. Long-term adverse consequences of these therapies may be possible but are unknown at this time. IV therapy is not FDA-approved to treat or prevent any illness or disease.
4. Benefits of intravenous therapy include:
    a. Injectables are not affected by stomach or intestinal absorption problems.
    b. Total amount of infusion is available to the tissues.
    c. Nutrients are forced into cells by means of a high concentration gradient.

d. Higher doses of nutrients can be given than possible by mouth without intestinal irritation.

(Initials)_____ I am aware that other unforeseeable complications could occur. I do not expect the nurse(s) and/or physician(s) to anticipate and or explain all risk and possible complications. I rely on the nurse(s) and/or physician(s) to exercise judgment during the course of treatment with regards to my procedure. I understand the risks and benefits of the procedure and have had the opportunity to have all of my questions answered.

(Initials)_____ I understand that I have the right to consent to or refuse any proposed treatment at any time prior to its performance. My signature on this form affirms that I have given my consent to IV Infusion Therapy, including any other procedures which, in the opinion of my physician(s) or others associated with this practice, may be indicated.

(Initials)_____ I understand that having IV Infusion Therapy can cause symptoms such as fever, fatigue, headaches, or nausea; please call if you have concerns or questions following your IV.

My signature below confirms that:

1. I understand the information provided on this form and agree to all the statements made above.
2. Intravenous (IV) Infusion Therapy has been adequately explained to me by my nurse and/or physician.
3. I have received all the information and explanation I desire concerning the procedure.
4. I authorize and consent to the performance of Intravenous (IV) Infusion Therapy.
5. I release the healthcare practitioner, Flatiron Functional Medicine, and all the staff from all liabilities for any complications or damages associated with my Intravenous (IV) Infusion Therapy.
6. I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.
7. To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern.

Patient's Name (please print): _____ Date of Birth: _____

Patient's Signature: _____ Date: _____

Healthcare Practitioner's Signature: _____ Date: _____