vitamindrip®

Informed Vitamindrip® / Intravenous Therapy Procedure Consent Form

I, _____ have the right to be informed about my health condition, and treatment so that I may make an informed decision, whether or not to undergo the Intravenous Therapy procedure after knowing the risks and hazards involved.

Vitamindrip® is a product that has been on the market worldwide. The procedure involves inserting a needle into the vein or muscle and injecting the formula described. Nutrients are forced into cells by means of a high concentration gradient. Higher doses of nutrients can be given than possible by mouth without intestinal irritation. Alternatives to intravenous therapy are oral supplementation and/or dietary and lifestyle changes. Each patient responds differently to Intravenous Therapy. No guarantee can be made with regard to the result or the length of time it will last. ____ **(Initial)**

I agree that I do not have any of the following medical conditions:

- Heart Failure
- Kidney Disease
- Liver Disease
- Cirrhosis or Ascites
- Recent Heart Attack
- Pleural Effusion(s), Pulmonary Edema
- Taking Diuretics (e.g. HCTZ, Lasix)
- Bleeding Abnormalities (e.g. Hemophilia, Von Willebrand Disease) ____ **(Initial)**

I have informed the staff of The Centre, P.C. of any known allergies to medications or other substances and of all current medications and supplements. I have fully informed the staff of The Centre, P.C. of my medical history. ____ **(Initial)**

Prior to treatment, a physician and/or nurse practitioner reviewed my complete medical history, reviewed the procedure and the technique he or she plans to use with me, and answered, to my best satisfaction, all questions I have regarding the treatment. Furthermore, I agree that I have received all the information and explanation I desire concerning the procedure. ____ **(Initial)**

Should complications develop from the procedure and additional costs are incurred, I agree that it will be my financial responsibility. Furthermore, if additional procedures, supplies, antibiotics, etc., are necessary, it will also be my responsibility. ____ **(Initial)**
All before and after care instructions have been explained and given to me. I understand my responsibility of properly following these instructions to minimize any risks of complications.
____ **(Initial)**

Risks of intravenous infusions include but are not limited to discomfort, bruising and pain at the site of injection, inflammation of the vein used for injection, and phlebitis. You may experience headaches, flushing, nausea, and/or dizziness that may persist for several days, but is generally temporary. Rarely, this procedure can cause severe allergic reaction, anaphylaxis, metabolic disturbance, cardiac arrest and even death. Except in emergencies, procedures are not performed

until you have had an opportunity to receive such information and to give my informed consent. I consent to and authorize the healthcare facility, physician and/or nurse located at 611 East Douglas, Suite 108 Mishawaka, IN 46545 to perform the above listed, to my body. ___ **(Initial)**

The nature and effects of the procedure, the risks and complications, if any involved, and other alternative methods of treatments, including the risks and benefits, have been fully explained to me, I understand them, and I assume all responsibilities. ____ **(Initial)**

I agree that this constitutes full disclosure, and that it supercedes any previous verbal or written disclosures. I certify that I have read and fully understand the above paragraphs and that I have had sufficient opportunity for discussion, to ask questions and have my questions answered. ____ **(Initial)**

I understand that this treatment will not be covered by insurance. I understand that I am responsible for all costs payable at the time of services. _____ **(Initial)**

Clinical results may vary, I acknowledge that no guarantee or assurance has been given by anyone as to the results, which may be obtained. Intravenous infusion therapy and any claims made about these infusions have not been evaluated by the US Food and Drug Administration and are not intended to diagnose, treat, cure, or prevent medical disease. These infusions are not a substitute for your physician's medical care. _____ **(Initial)**

I have the right to consent to or refuse the proposed treatment at any time prior to its performance. My signature on this form affirms that I have given my consent to the procedure(s) described above with any different or further procedures which, in the opinion of the physician and/or nurse may be indicated. ____ **(Initial)**

Cancellation Policy:

The Centre, P.C. staff allocates time and prepares a Vitamindrip® kit prior to each appointment which cannot be used in the event of a cancellation. We request that you reschedule or cancel your appointment at least 24-hours prior to the start time of your appointment otherwise your appointment and any payment(s) for service(s) will be forfeited. _____ **(Initial)**

I understand that all payment for services to The Centre, P.C. are non-refundable and all sales are final. ____ **(Initial)**

Informed Vitamindrip® / Intravenous Therapy Procedure Consent Form

By my signature below, I certify that I have read and fully understand the contents of this consent form. I was given the opportunity to have the physician and/or nurse practitioner cover any question or clarification I might have prior to signing this consent and thereby grant permission to perform the Intravenous Therapy procedure on me.

Signature – Patient	Print Name	Date / Time

Nurse Practitioner/Physician ("Provider")

I, the undersigned Provider, hereby certify that I have discussed the Vitamindrip® Intravenous Therapy procedure described in this consent form with this patient including:

- The risks and benefits of the procedure
- Any adverse reaction that may be reasonably expected to occur
- Alternative forms of treatment which may be medically viable
- I certify that the patient was encouraged to ask questions and that all questions were answered

Provider	Date / Time