SMART CHOICE
HEALTH AND WELLNESS CLINIC

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IV Therapy Consent Form

INITIALS PLUS SIGNATURE

Consent and Authorization for Intravenous Therapy Procedures

Name _____

DOB _____

INFORMED CONSENT FOR INTRAVENOUS (IV) THERAPY

This document is intended to serve as confirmation of informed consent for IV therapy as ordered by Smart Choice Health and Wellness Clinic, LLC.

☐ I have informed the nurse of any known allergies to drugs or other substances that may be included in the ingredients of my solutions, or of any past reactions to anesthetics.

☐ I have informed the nurse of all current medications and supplements.

I understand that I have the right to be informed during the procedure, 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.

The IV intravenous procedure involves inserting a needle into your vein and infusing over a determined period, prescribed nutrients (vitamins, minerals, amino acids).

You have the right to be informed of the procedure, any feasible alternative options, and the risks and benefits. The procedure involves inserting a needle into your vein or muscle and injecting the requested [nutrients] by patient or recommended by Provider.

a. Alternatives to intravenous therapy is oral supplementation and/or dietary and lifestyle changes.

b. Risks of intravenous therapy include:

- Discomfort, bruising and pain at the site of injection.
- Inflammation of the vein used for injection, phlebitis.
- Severe allergic reaction, anaphylaxis, cardiac arrest, and death.

c. Benefits of intravenous therapy include:

- Injectables are not affected by stomach or intestinal disease.
- Total amount of infusion is available to the tissues.

- 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.

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 therapy with any different or further procedure, which in the opinion of Smart Choice Health and Wellness Clinic LLC or other(s) associated with this clinic, may be indicated. I understand the information provided on this form and agree to the foregoing.

I understand that there is no implied or stated guarantee of success or effectiveness of any treatment. The procedure(s) set forth above has been adequately explained to me by my physician. I understand that I am free to [withdraw] my consent and to discontinue participation in their treatments at any time.

I understand that, except in emergencies, I must give 24 hours notice of intent to cancel or reschedule my appointment.

I understand that I will incur the full fee for treatment, regardless of amount used due to wasted materials. My signature below confirms that:

I have received all the information and explanation I desire concerning the procedure. I authorize and consent to the performance of the procedure(s).

Patient's Name _____

Date _____

Patient Signature _____ **Date** _____

ACKNOWLEDGEMENT OF NON-INSURANCE COVERAGE FOR SERVICES RENDERED

I agree, and it has been explained to me, that the following services performed at Smart Choice Health and Wellness Clinic, LLC are not generally considered and accepted with respect to insurance coverage.

- IV / Injection services and supplies
- Any supplements such as botanicals, homeopathic, nutraceuticals, etc.
- Other supplies, etc.

Usual and customary Evaluation and Management or other medically necessary services may be billable to my insurance, but IV / Injection services and supplies, supplements, and other supplies cannot be billed.

I understand that this requires my payment in full for all IV / Injection services, supplies, supplements, and I additionally understand that I may not attempt to bill my own insurance company for any of these services. Insurance deems these therapies investigational/experimental.

Patient's Name — Please Print _____

Provider's Name — Please Print _____

Patient's Signature _____ **Date** _____

Provider's Signature **Date**