IV CONSENT FORM

I_____request that _____IV therapy be given to me.

My physician has informed me that there are other modes of therapy for my illness. I understand that this procedure is experimental and not the standard of care. I understand that I may experience side effects such as: discomfort, nausea, itching, swelling, bruising, and/or infection at the injection site, GI cramping, headache, disorientation, increase in temperature, fatigue and muscle cramps which will be monitored very closely throughout the treatment.

I understand that most Vitamin IV therapies are not covered by insurance. I also realize that I will be personally responsible for payment at the time the services are rendered. At times, the office may provide you with billing codes (for certain IVs), when requested, which may be used for you to seek reimbursement from insurance.

I have read the above and have had the opportunity to ask questions and feel that I fully understand what I am signing and hereby request the IV therapy.

_____ _____

Signature of patient Signature of witness

_____

Date