

Medical Waiver

This procedure may be considered medically unnecessary. It may or may not medicate, alleviate, or cure the condition for which it has been indicated. This therapy has been recommended to you in the belief of its potential benefit in your current circumstance.

The procedure involves inserting a needle into a vein, placing a soft catheter, and infusing the elected therapy by healthcare provider acting within their active state regulated license/guidelines under the direction of a physician.

There are risks and side effects, although uncommon, to receiving IV therapy even when administered properly. While most side effects are rare, some may be experienced more commonly. This can vary from person to person due to current health and history. Some of the side effects can include but are not limited to:

- Discomfort burning/stinging sensation, and/or pain at the site of injection
- Sense of feeling or being swollen over the entire body (bloating)
- Changes in appearance of the skin and tissue at or around the insertion site (bruising)
- Inflammation of the vein used for injection/phlebitis
- Misplacement of the IV during insertion/infiltration
- Bleeding at the insertion site
- Scarring/injury at the insertion site, including but not limited to pain, nerve injury, and tissue necrosis
- Gastrointestinal upset: nausea, vomiting, diarrhea, constipation, indigestion, heartburn
- Metabolic disturbance: headache, allergic reactions (itching, hives, rash, swelling, difficulty breathing, wheezing, anaphylaxis), muscle spasms, weakness, fatigue, dizziness, infection, chills, fever
- Cardiovascular disturbances: Rapid heart rate, palpitations, chest pain, flushed face, vagal response, cardiac arrest, air embolism, and death

I assume responsibility to seek medical attention if any of the above side effects occur and are severe or are troublesome.

I have to the best of my knowledge, in written form notified the medical provider of known allergies, current medications/supplements, all past and current medical conditions/diseases/disorders, as well as any other pertinent personal/health/social/lifestyle information in order to minimize complications.

I understand that certain medications/supplements whether natural, over-the-counter or prescribed, as well as known or unknown medical conditions, may increase my risk of the above side effects.

I deny having and am aware of contraindications for receiving the proposed treatment including but not limited to: congestive heart failure, fluid retention, hemophilia, history of uncontrolled bleeding, kidney failure, kidney disease, myasthenia gravis, or pulmonary hypertension.

I am aware that other unforeseeable complications can occur. I do not expect the medical provider to anticipate and/or explain all risks and possible complications. I rely on the medical provider to exercise judgment during the course of treatment with regards to my procedure. I understand the procedure, the treatment, the risks/benefits of the procedure, have had the opportunity to have all my questions answered, and to have the right to refuse/stop treatment at any time.

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 the claim pertains to negligent administration of this procedure. I understand that the procedure(s) will be performed by or on behalf of the medical provider who is solely responsible for reviewing my information and medical history. I release Silver Birch Medical Clinic from any and all liability associated with the performance of the procedure(s).

I fully understand and confirm that the nature and purpose of the aforementioned treatment to be provided may be considered unproven by scientific testing or peer reviewed publications, therefore may be considered medically unnecessary or not currently indicated.

I assume responsibility for informing all current and future healthcare providers of my receiving the proposed treatment. I assume responsibility for discussing the appropriateness of my receiving the proposed treatment with my healthcare provider.

I hereby acknowledge that I understand that this procedure is not covered by my insurance. I agree to be personally and legally responsible for payment at the time of service for all services, including noncovered services.

I understand my personal information will be private and protected in compliance with HIPAA.

Upon your authorization and consent, this intravenous and or injection therapy will be performed on you by a medical provider. All invasive procedures carry the risk of unsuccessful results, complications such as rejection or infection, injury, or even death from both known and unforeseen circumstances, and no warranty or guarantee is made as to results or cure. You have the right to be informed of the nature of the procedure and its actual or potential risks, benefits, and side effects as well as any reasonable alternatives including the right to do nothing, and the side effects of such alternatives. You also have the right to give or refuse consent to any proposed procedure or therapy at any time prior to its performance. I acknowledge I have read the foregoing informed consent and agree to the treatment with its associated risks, known and unknown.

I hereby give consent to the medical provider to perform this and all subsequent intravenous treatments with the above understood. I hereby release Silver Birch Medical Clinic, the healthcare practitioner performing the procedure on behalf of Silver Birch Medical Clinic, and third-party suppliers from any and all liability related to the procedure.

Print Name

Sign Name

Date

Please CIRCLE your Clinic IV Infusion and/or IM Shot Below:

- | | |
|---------------------------|-------------------|
| 1. Rehydrate \$50 | B12 Shot \$20 |
| 2. Weekend Warrior \$75 | Steroid Shot \$60 |
| 3. Pain Relief \$75 | |
| 4. Recovery \$120 | |
| 5. Banana Bag \$150 | |
| 6. Meyer's Cocktail \$125 | |
| 7. Migraine \$100 | |

Add Ons:

- | | | | |
|-----------------------|---------------|--------------------|------------------|
| 1L Normal Saline \$25 | Thiamine \$10 | Folic Acid \$10 | Vitamin B12 \$20 |
| Magnesium \$10 | Toradol \$10 | Dexamethasone \$10 | |
| Benadryl \$10 | Zofran \$10 | Multivitamin \$60 | |

Total: _____

Payment Method: Cash Credit Card CashApp Venmo