Intravenous (IV) Nutrient Therapy Consent Form

This document is intended to serve as informed consent for your Intravenous (IV) Nutrient Therapy as determined by the physician and registered nurse at Lucky 13 Fuel Lounge, LLC

(Initials)_____ I have informed the nurse and /or physician of any known allergies to medications, foods, vitamins, supplements or other substances and of all current medications and supplements. I have fully informed the nurse and/or physician 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 IV Nutrient Therapy at Lucky 13 Fuel Lounge, LLC is only for otherwise healthy adults under the age of 65.

(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:

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 not limited to: a) Occasionally: Discomfort, bruising and pain at the site of injection. 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.
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 to anticipate and or explain all risk and possible complications. I rely on the nurse(s) and/or physician 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 Nutrient Therapy, including any other procedures which, in the opinion of my physician(s) or other associated with this practice, may be indicated.

(Initials)_____I understand that the benefits of IV infusions may be limited if I am an active smoker, live a sedentary lifestyle, and/or have a diet that contains an excess of calories and/or a deficiency of nutrients.

PAYMENT

Payment is due at the time of service, no exceptions. There has been no representation that this procedure is covered under my insurance plan or that I can/should seek such reimbursement. I agree to pay the full cost of the service even if the infusion is cancelled or is stopped at any time prior to completion at the discretion of the nurse, physician or myself.

I understand that I am responsible for the full cost of the procedure and agree to pay.

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) Nutrient 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 (IV) Nutrient Therapy.

Patient's Name and Date of Birth (Please Print)

Patient's Signature and Date

Registered Nurse or Phy sician's Name (Please Print)

Registered Nurse or Physician's Signature and Date
