IV VITAMIN THERAPY

CONSENT FORM

Full Name :
(PLEASE USE CAPITAL)

Date of Birth : _____/_____/_____ **Gender** : ☐ Male ☐ Female

Address : _____

Phone Number : _____ **E-Mail** :

MEDICAL HISTORY

Please list any known allergies:

Do you have any existing medical conditions? Yes No
If yes, please specify:

Are you currently taking any medications or supplements? Yes No
If yes, please list:

Have you previously received IV vitamin therapy? Yes No
If yes, please describe your experience:

Are you pregnant or breastfeeding? Yes No

Do you have any concerns or questions about the IV vitamin therapy procedure?

IV VITAMIN THERAPY

CONSENT FORM

IV VITAMIN THERAPY EXPLANATION:

IV Vitamin Therapy Explanation:

I, the undersigned, understand that IV vitamin therapy involves the administration of vitamins, minerals, and other nutrients directly into my bloodstream through an intravenous (IV) line.
This method of delivery may be used to address various health concerns or to enhance overall wellness. I acknowledge that the specific nutrients, dosages, and treatment plan will be determined by the healthcare provider based on my individual needs and goals.

Risks and Benefits:

I understand that IV vitamin therapy has potential benefits, including increased energy, improved hydration, and enhanced nutrient absorption. However, I also acknowledge that there are potential risks, such as infection, allergic reactions, and vein irritation. The healthcare provider has explained these risks to me, and I have had the opportunity to ask questions.

Consent for Treatment:

I voluntarily consent to receive IV vitamin therapy as recommended by the healthcare provider. I understand that the treatment plan may be adjusted based on my response and progress. I agree to inform the healthcare provider of any changes in my medical history, medications, or health status that may affect my treatment.

Financial Responsibility:

I understand that I am responsible for the cost of the IV vitamin therapy treatment. I have been informed of the fees associated with this service and agree to pay for the treatment at the time of service.

Confidentiality:

I acknowledge that my medical information and treatment records will be kept confidential in accordance with applicable laws and regulations.

If you have any concerns or questions at any point during your IV vitamin therapy, please don't hesitate to reach out.

Patient Signature: **Date:**

Healthcare Provider Statement:

I have discussed the risks, benefits, and alternatives of IV vitamin therapy with the patient. I believe that the potential benefits outweigh the risks, and I recommend this treatment based on the patient's medical history and needs.

Healthcare Provider Signature: **Date:**

THANK YOU FOR ENTRUSTING US WITH YOUR CARE, AND WE LOOK FORWARD TO ASSISTING YOU ON YOUR PATH TO IMPROVED HEALTH AND WELLNESS.

INVITA
IV VITAMINS THERAPY

IV VITAMIN THERAPY

INFORMED CONSENT FORM

RISKS AND BENEFITS:

I understand that IV vitamin therapy has potential benefits, including but not limited to:

- Enhanced nutrient absorption
- Increased energy
- Improved hydration
- Support for specific health concerns

However, I also acknowledge that there are potential risks, including but not limited to:

- Infection at the injection site
- Allergic reactions to the IV solution
- Vein irritation
- Pain or discomfort during the procedure
- Fainting or dizziness
- Bruising or bleeding at the injection site

The healthcare provider has explained these risks to me in detail, and I have had the opportunity to ask questions. I understand that individual responses to treatment may vary.

Patient Responsibilities:

I agree to:

- Provide accurate and complete medical information.
- Inform the healthcare provider of any changes in my medical history, medications, or health status.
- Report any adverse reactions or unexpected side effects during or after treatment.
- Follow any post-treatment care instructions provided by the healthcare provider.

Patient Signature: _____ **Date:** _____

Healthcare Provider Statement:

I have discussed the risks, benefits, and alternatives of IV vitamin therapy with the patient. I believe that the potential benefits outweigh the risks, and I recommend this treatment based on the patient's medical history and needs.

Healthcare Provider Signature: _____ **Date:** _____

THANK YOU FOR ENTRUSTING US WITH YOUR CARE, AND WE LOOK FORWARD TO ASSISTING YOU ON YOUR PATH TO IMPROVED HEALTH AND WELLNESS.

INVITA
IV VITAMINS THERAPY

IV VITAMIN THERAPY

TREATMENT PLAN FORM

PERSONAL INFORMATION

Full Name :
(PLEASE USE CAPITAL)

Date of Birth : _____/_____/_____ **Gender** : ☐ Male ☐ Female

Address : _____

Phone Number : _____ **E-Mail** : _____

Primary Care Physician Name:

Physician's Phone:

CURRENT SYMPTOMS OR HEALTH CONCERNS:

Patient's Current Health Concerns:
(e.g., fatigue, dehydration, immune support)

TREATMENT PLAN:

The following IV vitamin therapy treatment plan has been recommended for the patient:

Type of IV Therapy:

Description of IV Treatment:

IV VITAMIN THERAPY

TREATMENT PLAN FORM

TREATMENT SCHEDULE:

Frequency:

Duration of Treatment:

Estimated Number of Treatments:

Medications and Nutrients Included in the IV:
List of specific vitamins, minerals, and nutrients included in the IV treatment.

PRE-TREATMENT INSTRUCTIONS FOR THE PATIENT:

Hydration:

It is recommended that you stay well-hydrated before your IV treatment. Drink plenty of water in the 24 hours leading up to your appointment.

Fasting:

In some cases, fasting may be recommended for a specified period before the treatment. If fasting is required, follow the provided instructions closely.

Medication:

Continue taking your regular medications as prescribed unless otherwise advised by your healthcare provider.

Diet:

Avoid heavy, greasy, or spicy meals directly before your treatment. A light meal is recommended.

INVITA
IV VITAMINS THERAPY

IV VITAMIN THERAPY

TREATMENT PLAN FORM

POST-TREATMENT CARE INSTRUCTIONS FOR THE PATIENT

Hydration:

After the IV treatment, continue to stay well-hydrated by drinking water. Avoid excessive caffeine or alcohol consumption.

Activity:

You may resume your regular activities after the treatment unless otherwise advised by your healthcare provider.

Monitoring:

Pay attention to your body's response to the treatment. If you experience any unusual or severe side effects, contact your healthcare provider.

Diet:

Consume a balanced diet with essential nutrients to complement the IV treatment's benefits

PATIENT ACKNOWLEDGMENT:

I acknowledge that I have been provided with and understand the details of my IV vitamin therapy treatment plan, including the type of IV, treatment schedule, included nutrients, and both pre-treatment and post-treatment care instructions. I understand that this treatment plan has been recommended based on my current health concerns.

Patient Signature: _____ **Date:** _____

Healthcare Provider Statement:

I have recommended the IV vitamin therapy treatment plan as outlined above based on the patient's medical history and current health concerns.

Healthcare Provider Signature: _____ **Date:** _____

THANK YOU FOR ENTRUSTING US WITH YOUR CARE, AND WE LOOK FORWARD TO ASSISTING YOU ON YOUR PATH TO IMPROVED HEALTH AND WELLNESS.

IV VITAMIN THERAPY

APPOINTMENT SCHEDULING AND CANCELLATION POLICY

SCHEDULING APPOINTMENTS:

Appointment Request:

Appointments for IV vitamin therapy at **[Your Clinic Name]** can be scheduled through our website, by phone, or in person. We encourage patients to request appointments in advance to secure their preferred date and time.

Confirmation:

To confirm your appointment, you will receive a reminder notification via email or SMS. Please respond to this reminder to confirm your attendance.

Arrival Time:

We kindly request that you arrive at our clinic 10-15 minutes before your scheduled appointment time to allow for necessary paperwork and preparations.

CANCELLING OR RESCHEDULING APPOINTMENTS:

Notice Period:

If you need to cancel or reschedule your appointment, we ask for at least 24 hours' notice. This allows us to offer the appointment slot to another patient.

How to Cancel or Reschedule:

You can cancel or reschedule your appointment by calling our clinic during business hours or via the online appointment portal on our website.

Late Cancellation or No-Show:

If you cancel your appointment with less than 24 hours' notice or do not show up for your scheduled appointment, you may be subject to a cancellation fee.

CANCELLATION FEES:

Late Cancellation Fee:
A late cancellation fee of **[Specify Amount]** may be charged for appointments canceled with less than 24 hours' notice. This fee helps cover administrative and operational costs.

No-Show Fee:
A no-show fee of **[Specify Amount]** may be charged for patients who fail to attend their scheduled appointments without prior notice. This fee compensates for the reserved time and resources.

Exceptions:
We understand that unforeseen circumstances can arise. Exceptions to the cancellation and no-show policy may be considered in situations such as medical emergencies or severe weather conditions. Please contact our clinic to discuss any exceptional circumstances.

Policy Acknowledgment:
By scheduling an appointment with [Your Clinic Name], you acknowledge and agree to our Appointment Scheduling and Cancellation Policy. We kindly request your cooperation in adhering to the notice and fee requirements outlined in this policy.

INVITA
IV VITAMINS THERAPY

IV VITAMIN THERAPY

FEEDBACK AND EVALUATION FORM

PERSONAL INFORMATION

Full Name :
(PLEASE USE CAPITAL)

Date of Birth : _____/_____/_____ **Gender** : Male Female

Address : _____

Phone Number : _____ **E-Mail** : _____

Primary Care Physician Name:

Physician's Phone:

TREATMENT DETAILS:

Type of IV Therapy:

Healthcare Provider:

EVALUATION:

Overall Experience:

Please rate your overall experience with our clinic and the IV vitamin therapy session on a scale of 1 to 5, with 1 being the lowest and 5 being the highest.

1 2 3 4 5

Please provide comments or suggestions regarding your experience:

IV VITAMIN THERAPY

FEEDBACK AND EVALUATION FORM

EVALUATION:

Treatment Effectiveness:

Did you experience the desired benefits from the IV therapy treatment? Yes No

Please describe any noticeable effects or improvements:

Clinic Facilities:

Rate the cleanliness and comfort of our clinic on a scale of 1 to 5.

1 2 3 4 5

Staff Interaction:

Rate the friendliness and professionalism of our staff on a scale of 1 to 5.

1 2 3 4 5

Appointment Scheduling and Wait Time:

How satisfied were you with the ease of scheduling appointments and the wait time at our clinic? (circle one)

Very Satisfied Satisfied Neutral Dissatisfied Very Dissatisfied

Recommendation:

Would you recommend our IV vitamin therapy clinic to others? (circle one)

Very Satisfied Satisfied Neutral Dissatisfied Very Dissatisfied

Additional Comments:

Would you like to be contacted for further discussion about your feedback? Yes No

THANK YOU FOR TAKING THE TIME TO SHARE YOUR VALUABLE FEEDBACK WITH US. WE TRULY APPRECIATE YOUR INPUT, AND IT HELPS US ENHANCE THE QUALITY OF OUR SERVICES.

INVITA
IV VITAMINS THERAPY

IV VITAMIN THERAPY

PATIENT HEALTH FOLLOW-UP FORM

PERSONAL INFORMATION

Full Name :
(PLEASE USE CAPITAL)

Date of Birth : _____/_____/_____ **Gender** : ☐ Male ☐ Female

Address : _____

Phone Number : _____ **E-Mail** : _____

HEALTHCARE PROVIDER INFORMATION:

Healthcare Provider:

Date of Previous Treatment:

CHANGES IN HEALTH:

Please share any health-related changes you've observed since your previous IV vitamin therapy treatment.

Overall Well-being:

Please rate your overall sense of well-being on a scale of 1 to 5, with 1 being the lowest and 5 being the highest

(1) (2) (3) (4) (5)

Symptoms and Health Improvements:

Please check the specific improvements or changes in symptoms you have experienced, if any:

Increased energy	☐	Yes	☐	No
Reduced fatigue	☐	Yes	☐	No
Better hydration	☐	Yes	☐	No
Improved mood	☐	Yes	☐	No
Enhanced focus	☐	Yes	☐	No
Reduced pain/discomfort	☐	Yes	☐	No
Improved sleep quality	☐	Yes	☐	No
Other (please specify):	☐	Yes	☐	No