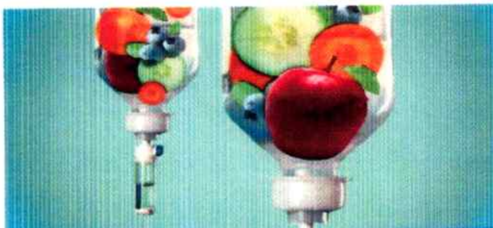
ALLURE HEALTH AND WELLNESS

Drench your body in nutrients - Feel energized and vibrant - Look and feel better than ever

Intravenous (IV) Infusion Therapy at Allure Health and Wellness



1. **Get Up and Go** - Burn fat, feel energized and boost metabolism. Delivers extra B vitamins to increase your energy, improve your mood and help your body deal with stress. Since B vitamins also increase your metabolism, this booster is ideal for patients who want to maximize their weight loss efforts - Price $: Depending on market cost

2. **Immunity** - Boost your immune system and feel better faster. Delivers extra Vitamin C to help your body prevent or fight a cold or flu, allergies or any illness. Since Vitamin C also helps your body heal faster, this booster is ideal for post-surgical patients - Price $: Depending on market cost

3. **Reboot** - Did you overindulge last night? The Morning After Infusion delivers extra hydration, plus additional vitamins and minerals directly into your bloodstream along with medications for nausea and headaches to help you recover quickly from a hangover - Price $: Depending on market cost

Checklist of what to bring:

- □ Your completed Intravenous (IV) Infusion Therapy Intake Form
- □ A list of all prescription medications, OTC medications, vitamins/supplements that you take □ A copy of your most recent blood work is helpful
- □ Your signed Consent Form
- □ Your signed HIPAA Notice
- □ Make sure you are well hydrated prior to your visit. We suggest drinking 1-2 16oz. bottles of water. Dehydration can make it difficult to insert an IV.
- □ Make sure you eat something prior to your visit. We suggest a high protein snack, such as nuts, seeds, a protein bar, cheese, yogurt or eggs. Low blood sugar can make you feel weak, light-headed or dizzy.

During your first visit for IV Vitamin Therapy infusions:

During the first visit, a Registered Nurse will discuss your main complaints and desired outcomes with you. The RN will review your medical & surgical history and any medications you are taking. Based on this assessment, your Intravenous (IV) infusion will be customized to address your individual needs. If you have any complex medical conditions, the physician at Allure Health and wellness may request you obtain blood work or further testing and/or your personal physician's approval prior to administering any IV infusions.

What to expect:

The IVs used during your Intravenous (IV) infusion therapy are exactly the same that you would find in a hospital. Instead of a clinical experience though, our IV infusions are given in a peaceful spa setting and leave you feeling calm, relaxed, and refreshed.

Depending on your customized IV cocktail, the infusion can be finished in as little as 20-30 minutes. Our friendly and attentive staff will keep you calm, cared for, and comfortable during your infusion. Patients find the experience tranquil and healing. Patients leave feeling vibrant, energized, and refreshed.

INTRAVENOUS (IV) INFUSION THERAPY INTAKE FORM

Patient Information:

Name:____Date:

Address:

City:_State:_ZIP Code:

Phone:_(H) (C) (other) Date of Birth:_(MM/DD/YY) Age: _________ Sex: M / F Occupation:_Email

address:

In case of emergency, please contact: Name: Phone: How did you hear about us? Internet Facebook Walk-in

Friend: ______________________ **What are your main complaints?** (Please check all that apply)

□ Fatigue or low energy
□ Stress
□ Poor diet due to busy lifestyle □ Brain fog or trouble concentrating □ Low mood or depression
□ Headaches or migraines
□ Weight gain or difficulty losing weight □ Slow metabolism

□ Asthma and Allergies
□ Recent surgical procedure □ Recent illness
□ Cold or flu symptoms
□ Facial wrinkles or fine lines □ Dull or dry skin
□ Malabsorption issues
□ Other ______________________

Which statements best describe why you are here today? (Please check all that apply)

□ I want to have more energy and feel better overall
□ I want to do everything I can to nourish my body
□ I want to do everything I can to enhance my weight loss efforts
□ I want to prevent getting sick
□ I want to recover quickly from my surgery or illness
□ I want to slow the aging process
□ I want to feel and look younger
□ I want to have smoother, brighter and more vibrant skin
□ I want to cleanse my body of toxins
□ I want to recover quickly from a hangover
□ Other ______________________________________

MEDICAL HISTORY

Are you pregnant or breastfeeding? Yes / No

Date of last chemistry screen or other lab testing ____________________

Have you ever been told that you have an electrolyte imbalance or other abnormal labs? (Please check all that apply)

- ☐ Hypermagnesemia (High magnesium levels)
- ☐ Hypercalcemia (High calcium levels)
- ☐ Hypokalemia (Low potassium levels)
- ☐ Hemochromatosis (High iron levels)
- ☐ Other ________________________

Are you a diabetic? Yes / No

Are you a smoker? Yes / No If Yes, how much do you smoke? ______________________________ How many alcoholic drinks do you consume in a week? ______________________________________ Do you use any recreational drugs? Yes / No

If Yes, which ones and how often? ____

Please list everything you are currently taking:

Prescription Medications – Strength – Frequency – Condition being treated

____

____ Over the Counter Drugs – Strength – Frequency – Condition being treated

____

____

Vitamins and Other Supplements – Strength – Frequency – Condition being treated

____

____

Name and DOB: ____

MEDICAL HISTORY CONTINUED

Do you take Digoxin (Lanoxin) for a heart problem? Yes / No
Do you take any diuretics or water pills? Yes / No If Yes, please list: ______________________ Do you take any steroids, i.e. Prednisone? Yes / No If Yes, please list: ______________________ Do you have any medication or food allergies? Yes / No If Yes, please list: ______________________

Do you have any of the following conditions? (Please check all that apply)

- □ Blood pressure problems (High or low)
- □ Heart Problems
- □ Stroke or "mini-stroke"
- □ Kidney Problems
- □ Kidney Stones
- □ Asthma
- □ Optic Nerve Atrophy or Leber's Disease
- □ Sickle Cell Anemia
- □ G6PD Deficiency
- □ Sarcoidosis
- □ Parathyroid problems (High levels)

List any other medical conditions you have (not mentioned above):

____

____

List of all surgical procedures you've had with approximate dates:

____

____

Is there anything else you'd like the nurse and physician to know?

____

____

Name and DOB: ______________________________________

Intravenous (IV) Infusion Therapy

Intravenous (IV) Infusion Therapy Consent Form

This document is intended to serve as informed consent for your Intravenous (IV) Infusion Therapy as ordered by the physician at Allure Health Clinic.

(Initials)_________ I have informed the nurse and/or physician of any known allergies to medications 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 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(s) to anticipate and or explain all risk and possible complications. I rely on the nurse(s) and/or physician(s) 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 Infusion Therapy, including any other procedures which, in the opinion of my physician(s) or other associated with this practice, may be indicated.

My signature below confirms that:

1. I understand the information provided on this form and agree with all statements made above. 2.

Intravenous (IV) Infusion 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 Intravenous (IV) Infusion Therapy.
5. I release Nurse Practitioner, Allure Health Clinic, and all the medical staff from all liabilities for any complications or damages associated with my Intravenous (IV) Infusion Therapy.

Patient's Name and Date of Birth- Please Print ______________________________

Patient's Signature and Date ______________________________

Registered Nurse or Physician's Name - Please Print ______________________________

Registered Nurse or Physician's Signature and Date ______________________________

HIPAA NOTICE OF PRIVACY PRACTICES

PATIENT AUTHORIZATION FOR SPECIFIC DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: ____

I, the undersigned, hereby authorize ____________________________ ("Provider") to disclose certain information (described below) about me to **Allure Health and Wellness** for purposes of assisting Provider (or one of Provider's employees and agents) in the IV Hydration process and/or for general training and educational purposes.

I acknowledge and agree that my information may be used in **Allure Health and Wellness** training or website instruction or in connection with certification and renewal of certification examinations.

Provider is hereby authorized to disclose the following protected health information: my name, birth date, dates of services, treatment records that include treatment technique in your medical history, any unaltered x-rays used for diagnosis.

I understand that signing this Authorization is voluntary and that my treatment, payment, or eligibility for benefits will not be conditioned upon execution of this Authorization. I understand that if my protected health information is disclosed to someone who is not required to comply with HIPAA, then such information may be subject to re-disclosure by the recipient and no longer protected.

This Authorization shall expire one (1) year from the date of my signature, unless I revoke this Authorization sooner.

I understand that I may revoke this Authorization at any time by delivering a revocation in writing to the Provider. I understand that, if I revoke this Authorization, it will have no effect on actions already taken by Provider or Allure Health and Wellness in reliance on this Authorization.

I have read and understand the terms of this Authorization, and I agree to those terms.

______________________________________ ______________________

Signature of Patient or Guardian, if applicable Date

______________________________________ ______________________________________

Name of Guardian, if applicable Relationship of Guardian to Patient, if applicable

A signed copy of this Authorization must be provided to the patient and attached to the patient's medical record. A copy of this Authorization is as effective as the original.

Discharge Instructions for Intravenous (IV) Infusion Therapy

How to care for yourself after your IV Vitamin Therapy infusion:

- Apply pressure to site for 2 minutes after IV has been removed
- Keep Band-Aid in place for 1 hour
- Warm packs and elevating your arm can be used for any bruising at the site
- Cold packs can be used for pain relief and to decrease any swelling at the site
- Any swelling should be significantly reduced in 24 hours
- Post IV infusion symptoms are uncommon. Dehydration is the cause of most symptoms and concerns. • We encourage you to drink at least 1-2 16oz. bottles of water after your IV infusion.
- If enough water is not consumed, you may experience any of the following symptoms: headaches, nausea, joint pain, blurred vision, cramping (GI and/or muscular), mental confusion or disorientation.

Most patients experience significant overall improvements:

- Better energy
- Better mental clarity
- Improved sleep
- Improvement of their complaints
- Overall feelings of well being

Patients commonly report one of two patterns after an IV Vitamin Therapy infusion:

- Patients generally feel better right away. Due to a busy lifestyle, many people are chronically dehydrated and deficient in vitamins and minerals causing them to not feel well. Once the patient is hydrated and the nutrients are replaced, their symptoms improve quickly.
- Patients sometimes feel tired or unwell. These patients are generally in the process of detoxifying. When toxins are pulled out of tissues, they re-enter the bloodstream. They remain poisons, but they are now on their way OUT instead of on their way IN. Even when patients do not feel well at this stage, the process is one of healing and cleansing. After this period, an overall improvement in one's sense of well-being is generally reported.

How often will I need IV Vitamin Therapy infusions?

The number and frequency of treatments will vary depending on certain factors.

- Condition(s) being treated
- Current health status of the patient
- Response of the patient to the treatments

A general estimate of the number of treatments needed is discussed during the first visit. As we go along, we will develop a more specific treatment plan. Most patients will require at least 5-10 treatments. Depending on the response, some patients will then go on to maintenance therapy with occasional treatments.

Call Allure Health and Wellness or your Primary Care Physician for:

- Any symptoms you are not comfortable with
- If any of the following are progressively worsening after your IV infusion:
  - Significant swelling over the IV site
  - Redness over the vein that is increasing in size
  - Pain in the vein/arm that is not improving over an 8-12 hour period
  - Headache that does not resolve with increased hydration or over-the-counter pain relievers like aspirin, Acetaminophen or Ibuprofen.

If you feel like you are having a life threatening emergency, please call 911.