



Informed Consent for NAD+ and FastVitaminIV

I, _____, hereby give my voluntary consent to receive intravenous (IV) nicotinamide adenine dinucleotide (NAD) followed by FastVitaminIV per the outlined protocol. The procedure is to be administered by the licensed nursing staff of FastVitaminIV™ under the direct orders of Anil George, Medical Director of NFIM and the direction of Craig Koniver, MD.

Brain Refuel + FastVitaminIV is a comprehensive amino acid, vitamin, and mineral treatment given for a variety of conditions. These amino acids, vitamins, and minerals are primarily administered through an IV over a consecutive 5 or 10-day period or a one-time treatment. Treatment is on an outpatient basis.

I FULLY UNDERSTAND AND AM FULLY AWARE THAT:

_____ The desired effect, improvement, or relief of any condition for which Brain Refuel is to be applied may or may not be attained. Moreover, Brain Refuel does not preclude the need for other forms of therapy and I assume full responsibility for the treatment of my condition by other physicians practicing standard medicine, as may be deemed necessary for my well-being.

_____ There may be complications resulting from this procedure which could include but are not limited to infection, nausea, vomiting, diarrhea, pain and discomfort, weakness, fainting, micro-hemorrhages, ecchymosis, embolism, allergic reactions, shock, IV fluid infiltration, swelling, needle breakage and its retention, death, and even aggravation of current symptoms. Most patients report mild symptoms during the administration of NAD and the vitamin mixture that are transient.

_____ No assurances or guarantees have been made, nor can any be made concerning the results that may be obtained, but the physicians and nurses who will provide the treatment which I will undergo will perform their services, and take such precautions that are consistent with the standards of care that prevail for the same type of treatment provided to patients with conditions similar to mine.

By signing this consent form I have not waived any of my legal rights or released this institution from liability for negligence. I also understand that I may revoke my consent at any time and withdraw from any further treatment without prejudice. My signature below confirms that:

1. I understand the information provided on this form and agree the procedure(s) set forth above have been adequately explained to me by my nurse/physician.
2. I have received all the information and explanation I desire concerning the procedure.
3. I certify that I am not pregnant during any current or future treatment.
4. I certify that I am not intoxicated on alcohol or any illicit drugs during any future treatment.

Signature and Printed Name of Patient or Legal Guardian

Date