IV NUTRITION THERAPY

Acknowledgement of Non-Insurance Coverage for Services Rendered

I agree, and it has been explained to me that the following services performed at the Cedar Street Medical IV Hydration Lounge are not generally considered and accepted with respect to insurance coverage.

- IV/Injection services and supplies
- Any supplements such as botanicals, homeopathic, nutraceuticals, etc.
- Other supplies such as Kinesio Tape, etc.

Usual and customary evaluation and management or other medically necessary services may be billable to my insurance, but IV/Injection services and supplies, supplements, and other supplies such as Kinesio Tape cannot be billed.

I understand that this requires my payment in full for all IV/Injection services, supplies, supplements, and I additionally understand that I may not attempt to bill my own insurance company for any of these services.

_____ _____

Patient Name (PRINT) Date

_____ _____

Patient's Signature Date

_____ _____

Provider/Clinician's Signature Date

IV INTAKE FORM

Cedar Street Medical
Primary Care & Wellness
Est. 2023

Patient Name: _____ Date: _____

Age: _____ Sex: _____

Prescriptions/Frequency:_____
_____
_____

Past Medical History- Has patient ever been diagnosed with:

- ☐ Hypertension
- ☐ Angina
- ☐ Ankle swelling
- ☐ Arrhythmia
- ☐ CHF
- ☐ MI
- ☐ Abnormal EKG
- ☐ Kidney Disease
- ☐ General Edema
- ☐ Bleeding Disorder
- ☐ Asthma
- ☐ Pulmonary Edema
- ☐ Sudden Weight Loss
- ☐ Diabetes Type I or II
- ☐ Anxiety/Panic Attacks
- ☐ Is Patient Pregnant
- ☐ G6PD Deficiency

Allergic reactions (specific): _____

Pertinent details of conditions checked above:
_____
_____

TO BE FILLED OUT BY IV TEAM MEMBER

Date of 1st Intake: _____

Known Allergens: _____

Allergic to: Latex_____ Shellfish _____ Iodine _____

Reaction: _____

Presence of Edema _____ Lung Sounds _____ Heart Sounds _____

Vitals

BP: _____ Pulse: _____ Resp: _____

Temp: _____ Wt: _____ Hight: _____

Cedar Street Medical

Primary Care & Wellness

Est. 2023

IV/IM NUTRITION

Consent and Authorization for Intravenous Therapy Procedures

Patient Name: _____

Procedure: _____

This practice provides facilities and personnel to assist your physician in the performance of intravenous therapy. You 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 you have had an opportunity to receive such information and to give your informed consent.

- The procedure involves inserting a needle into your vein or muscle and injecting the formula described above by your physician or clinician.
- Alternatives to intravenous therapy are oral supplementations and/or dietary and lifestyle changes.
- Risks of intravenous therapy include:
    a. Discomfort, bruising, and pain at the injection site.
    b. Inflammation of the vein used for injection, phlebitis.
    c. Severe allergic reaction, anaphylaxis, cardiac arrest and death.
- Benefits of intravenous therapy include:
    a. Injectables are not affected by stomach or intestinal disease.
    b. Total amount of infusion is available to the tissues.
    c. Nutrients are forced into cells by means of high concentration gradient.
    d. Higher doses of nutrients can be given than possible by mouth without intestinal irritation.

You have the right to consent to or refuse and proposed treatment at any time prior to its performance. Your signature on this form affirms that you have given your consent to the procedures(s) described above with any different or further procedures which, in the opinion of your physician, may be indicated.

The procedure will be performed by or under the direction of the physician named above with qualified medical assistants.

Your signature below means that:

- You understand the information provided on this form and agree to the foregoing.
- The procedure(s) set forth above has been adequately explained to you by your physician/clinician.
- You have received all the information and explanation you desire concerning the procedure.
- You authorize and consent to the performance of the procedure(s).

Signature: _____ Date: _____ Time: _____

Witness: _____ Date: _____ Time: _____