

i.hydrate

A division of Improve Health Solutions MedSpa

200 Atlantic Ave

Manasquan NJ 08736

866-807-8686 or text 973-556-4338

www.ihydrateiv.com

INFORMED CONSENT FOR IV VITAMIN THERAPY

This document is intended to serve as confirmation of informed consent for IV therapy.

I have informed the qualified staff members of any known allergies to drugs and or other substances or any past reactions to any drugs. I have informed the staff members of any current medications and over the counter supplements.

I understand that I have the right to be informed of the procedure, including risks and benefits. Except in emergencies, procedures are not performed until I have had the opportunity to receive such information and give my informed consent.

I understand that :

- The procedure involves inserting a needle into a vein and injecting the prescribed therapy intravenously.

- Alternatives to IV therapy are oral supplements and or dietary and lifestyle changes
- RISKS: include but not limited to : discomfort , bruising , pain at the site of injection; inflammation of the vein, metabolic disturbances, severe allergic reactions , anaphylaxis , infection, and extremely rare, cardiac arrest and death
- BENEFITS : Injectables are not affected by the stomach / intestinal absorption, total amount of infusion is available to tissues, higher doses or nutrients can be given without causing any intestinal irritation, 100% absorption of vitamins and nutrients

I understand that the following can reduce the efficacy of IV Therapy: cigarette smoking, certain medications, caffeine consumption increases Vitamin C excretion , poor diet, heavy metal toxicity

I am aware that other unforeseeable complications could occur . I do not expect the physician and or qualified practitioners to anticipate and explain all risk and possible complications. I rely on the physician and qualified staff members to exercise judgement during he course of the treatment with regards to my procedure.

I understand that IV Therapy is NOT covered by insurance and I understand that I will be responsible for all services rendered,

I understand that IV Vitamin therapy is NOT FDA APPROVED for treatment of any disease.

I understand the risks and benefits of the procedure and have had the opportunity to have my questions answered.

My signature on this form affirms that I have given my consent to IV therapy.

I have read and understand the information in this form, all my questions answered and are knowledgeable about the conventional treatments available. I am aware that the IV Vitamin therapy is not FDA approved and is considered unconventional and long term consequences of these therapies may be possible but are unknown at this time.

The provider has explained the procedure to me.

I authorize and consent to the performance of the procedure as agreed upon.

By Signing this consent, I understand the risks , and I am willing to accept the risk. I have been advised that this therapy may or may not be beneficial in my condition. I understand the benefits of this treatment will be enhanced by engaging in positive lifestyle such as exercise, proper diet , and nutritional supplementation as has been recommended by my healthcare practitioner.

By signing below, I ACKNOWLEDGE AND CERTIFY, THAT I HAVE READ AND UNDERSTAND THE CONSENT, RELEASE AND INDEMNITY AGREEMENT FOR THIS PROCEDURE AND THAT I AM SIGNING IT VOLUNTARILY.

Client signature

date

Clinician Signature

date

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