RIOS HEALTH & BEAUTY
ENHANCING BEAUTY, NOURISHING HEALTH

IV THERAPHY
CONSULTATION FORM

Name : _____ Date : _____

Date of birth : _____ Age : _____ □Male □Female □ Non-Binary

Address: _____

City: _____State : _____ Zip Code : _____

Phone:_____ Email : _____

Emergency Contact: _____ Phone Number: _____

How did you hear about us?_____

Are you referred by someone? If so, whom?_____

Would you like to be added to our email list for news and exclusive offers? _____

MEDICAL HISTORY

What are your main complaints? (Please check all that apply)**lease mark any of the following conditions you may currently have.**

□ 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
□ Recent surgical procedure
□ Recent illness
□ Cold or flu symptoms
□ Facial wrinkles or fine lines
□ Dull or dry skin
□ Malabsorption issues
□ Other _____

Any other conditions? _____

If you ticked any boxes, please give further details _____

Do you have any allergies? □ Yes □ No

If so, please list all _____

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? _____

List all medications you take, including vitamins, herbal supplements, aspirin, hormones, and topical

_____

_____

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 slow the aging process**
□ **I want to feel and look younger**
□ **I want to have smoother, brighter, and more vibrant skin**
□ **I want to recover quickly from a hangover**
□ **Other** _____

_____

Are you currently taking blood thinning medication? ☐ **No** ☐ **Yes**
If yes, please explain:

_____

Are you pregnant or trying to get pregnant? ☐ **No** ☐ **Yes**

If yes, please explain:

_____

_____

Have you had any adverse reactions to any previous treatment ☐ **No** ☐ **Yes**
If yes, please explain:

_____

_____

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** _____

<u>By signing below, you agree to the following:</u>
I have completed this form truthfully and to the best of my knowledge. I agree to waive all liabilities toward my medical members and the employer for any injury or damages incurred due to any falsification of my medical history

_____ _____

Patient Name (Printed) **Patient Signature**

_____

Date

During your first visit for IV Vitamin Therapy infusions:

During the first visit, the provider will discuss your main complaints and desired outcomes with you. The provider 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 provider at Rios Health and Beauty may request you obtain blood work or further testing and/or your personal provider's approval prior to administering any IV infusions.

What to expect:

The IVs used during you 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.

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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 provider at Rios Health & Beauty.

(Initials)_____ I have informed the nurse and/or provider of any known allergies to medications or other substances and of all current medications and supplements. I have fully informed the nurse and/or provider 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 provider'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 are 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 provider(s) to anticipate and or explain all risk and possible complications. I rely on the nurse(s) and/or provider(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 provider(s) or others associated with this practice, may be indicated.

My signature below confirms that:

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

2. Intravenous (IV) Infusion Therapy has been adequately explained to me by my nurse and/or provider.
3. I have received all the information and explanations I desire concerning the procedure.

4. I authorize and consent to the performance of Intravenous (IV) Infusion Therapy.

5. I release Rios Health and Beauty, 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 _____

Provider's Name – Please Print _____

Provider's Signature and Date _____

Discharge Instructions for Intravenous (IV) Infusion Therapy

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

• Apply pressure to the site for 2 minutes after the 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 Rios Health and Beauty 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.

IV THERAPY

PHOTO AND VIDEO RELEASE FORM

I, _____ hereby grant and authorize **RIOS HEALTH AND BEAUTY.** I grant the right to capture, modify, edit, reproduce, exhibit, publish, distribute, and utilize any photographs, videos, and/or audio recordings taken of me for lawful promotional purposes. These materials may include but are not limited to, newspapers, flyers, posters, brochures, advertisements, press kits, websites, social media platforms, and other forms of print and digital communication. I provide this authorization without expecting any payment or other forms of consideration.

This authorization remains in effect indefinitely and applies to all languages, media, formats, and markets, whether currently known or discovered in the future.

I willingly waive any rights to royalties or other compensation arising from or related to the use of these photographs or recordings.

I acknowledge and accept that the materials created through this agreement will be the property of **RIOS HEALTH AND BEAUTY** and will not be returned to me.

I hereby release and discharge **RIOS HEALTH AND BEAUTY**, from any liability, claims, or legal actions that may arise, including those made by myself, my heirs, representatives, executors, administrators, or any other individuals acting on my behalf or on behalf of my estate.

By signing below, I confirm that I have thoroughly read and comprehended the entirety of the release agreement stated above.

By signing below, I hereby acknowledge that I have completely read and fully understand the above release agreement

_____	_____	_____
Patient Name (Printed)	Patient (signature)	Date

RIOS HEALTH & BEAUTY
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IV THERAPY
CANCELATION POLICY

To ensure the provision of high-quality care within a reasonable timeframe, we have implemented an appointment and cancellation policy.

As appointments are in high demand, canceling your appointment in advance allows us to offer the time slot to another individual seeking timely care. This policy helps us optimize our appointment availability for all clients.

During the appointment booking process, you will be required to make a $50 deposit, which will be applied as a credit towards your scheduled treatments.

We understand that circumstances may arise requiring you to cancel or reschedule your appointment. To avoid any inconvenience, please notify us at least 72 hours before your scheduled appointment. In such cases, your deposit will either be refunded or applied towards a future appointment. However, if you provide less than 72 hours notice, a cancellation fee will be charged.

Please note that if you arrive more than 15 minutes late for your appointment, it will be considered a no-show, and the cancellation fee will be applied.

We are more than happy to address any inquiries or concerns you may have regarding our cancellation policy.

I have read and fully understand the above Appointment Cancellation Policy and agree to be bound by its terms. I agree to pay the cancellation fee in the event of a missed appointment.

Patient Name (Printed)	Patient (signature)	Date