Center for Seeking Peace
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Informed Consent: Elective Intravenous (IV) Fluid Therapy

This consent form is inclusive of multiple elective Intravenous Therapy additives that may or may not include, and is not limited to: Hydration Fluids, Electrolyte Supplementation, Mineral Supplementation, Vitamin Supplementation, Anti-Nausea Medication, Non-Narcotic Pain Reliever, Amino Acid Supplementation, and/or Antioxidant Supplementation.

Informed Consent Instructions: This is an informed consent document to provide written information about the above-named treatment regarding risks, benefits, and alternatives. It is important that you understand the information provided to you before proceeding with this treatment; please ask your healthcare professional any/all questions before signing this consent form.

Name:_____ **DOB:**_____ **Date:**_____

I read, write, and understand English. **Initials:** _____

I,_____, authorize Center for Seeking Peace to administer elective Intravenous (IV) therapy for the intended purpose of managing or alleviating symptoms at my request. I understand I am being treated for subjective symptoms and is **not** providing a medical-related diagnosis or medical treatment plan.

Treatment Provider: **Genise Binns, PMHNP** **Date:** ____/____/____

Purpose of Treatment and General Information:

Intravenous Therapy (hereafter referred to as "IV Therapy", "IV Infusion", or "IV Treatment") can be administered on an as-needed basis to help mitigate or alleviate subjective symptoms. IV treatment frequency, IV treatment dosing, and IV treatment suitability will be determined by your treatment provider based on your individual needs.

Center for Seeking Peace is providing a combination of intravenously infused vitamins, minerals, supplemental boosts, and/or non-narcotic pain and/or nausea relief. This procedure is recommended for replacement of essential nutrients, correction of aforementioned deficiencies, and for other therapeutic effects, including, but not limited to: improving immune function, improving antioxidant status, reducing oxidative damage, decreasing bronchospasm, improving fatigue, relieving nausea, reducing migraine pain, etc. Intravenous infusions are the fastest, most efficient way for your body to receive hydration, micronutrients, and/or non-narcotic pain/nausea relief. Essential nutrients and/or medications are delivered to the bloodstream where your cells can begin to uptake what your body needs right away to help alleviate your symptoms.

What To Expect During Treatment: Your treatment provider will begin treatment by completing a consultation to assess your individual needs and any contraindications you may have to your desired treatment. Your skin will then be prepped with an alcohol solution and an IV needle will be inserted into your vein to place an intravenous cannula. Once a successful IV has been placed into your vein, your IV Therapy will be infused over a determined period of time to deliver your combination of prescribed nutrients (vitamins, minerals, amino acids, etc). Treatment duration can take around 20-60 minutes total. There is no downtime associated with this treatment. You can expect some minor discomfort near the IV insertion site, which should subside soon after the IV cannula is removed. Most clients receiving IV therapy report feeling an improvement in symptoms, however, individual results will vary. There is no guarantee you will feel symptom relief after IV infusion, nor does your improvement of symptoms exclude other coexisting potential medical conditions, nor does treatment substitute or replace medical care.

I understand the treatment goal is to alleviate subjective symptoms and that there is no implied or stated guarantee of success or effectiveness of any treatment. **Initials:** _____

Continued on next page

Treatment Benefits:

IV Infusion Therapy Benefits may include:

- Infusions enter your bloodstream, allowing the total dosing to be available to your cells and tissues.
- Infusions bypass any possible stomach and/or intestinal absorption disturbances.
- Higher doses of nutrients can be given intravenously than can be given by mouth and without causing stomach/intestinal irritation.

I understand the possible benefits of IV Infusion Therapy. **Initials:** _____

Alternative Treatments:

Alternative forms of treatment to IV Infusion Therapy are: No treatment whatsoever, oral supplementation of nutrients and/or medications, intramuscular supplementation/injection, and/or dietary and lifestyle changes.

It has been explained to me that alternative treatments are available. **Initials:** _____

Possible Risks and Side Effects:

The possible side effects and risks of IV Infusion Therapy include, but are not limited to:

1. General Side Effects: I understand there is a risk of swelling, discomfort, local numbness, pain at the treatment site, bruising, allergic reaction, facial flushing, or irritation of the skin that may occur.

2. Infection/Phlebitis: Although rare, if an infection occurs as a result of treatment at IV insertion site or in the vein used for infusion (phlebitis), additional treatment including antibiotics or an additional procedure may be necessary.

3. Allergic Reaction: Although rare, allergic reactions may include: hives, difficulty breathing, swelling of your face, lips, tongue, or throat; additional treatment may be necessary should an allergic reaction occur.

4. Redness/Swelling/Bruising/Scarring: Some redness, swelling, and/or bruising may occur at the IV insertion site. On rare occasions, this may lead to scarring.

5. Peripheral Vascular Thrombosis/Air Embolism: Although rare, a peripheral blood clot (thrombosis) and/or Air Embolism may result as a side effect of treatment and may require additional treatment.

6. Headaches/Dizziness/Fainting/Metabolic Disturbance: As a result of treatment, or as a pre-existing condition, you may experience headaches, dizziness, fainting, and/or metabolic disturbances after receiving treatment. It is important to disclose all pre-existing conditions and recent lab workups on your intake questionnaire and/or during consultation.

7. Hypervolemia/Volume Overload: On rare occasions, fluid or volume overload may occur as a result of treatment and/or due to pre-existing condition. Signs/Symptoms of fluid overload may include: ascites (abdominal swelling), edema (swelling) in extremities, dyspnea (shortness of breath), and elevated heart rate. Clients with a history of Congestive Heart Failure (CHF), Chronic Kidney Disease (CKD), and Liver Cirrhosis are at risk of developing hypervolemia from elective IV Therapy; please notify staff immediately if you have any aforementioned conditions.

8. IV Infiltration and Extravasation: IV Infiltration is the accidental leakage of the treatment solutions out of the vein and into surrounding tissues, which may cause swelling at or near the IV site, pain, skin discoloration, numbness, and impaired blood circulation. **Should your IV fail due to infiltration, treatment will be stopped and a new IV site will need to be started.** On rare occasions and depending upon what is being administered, extravasation (tissue injury) may occur as a result of treatment and may require additional treatment.

This list is not meant to be inclusive of all possible risks associated with IV Infusion Therapy, as there are both known- and unknown- side effects associated with any medication or procedure.

I have read and understand possible risks, side effects, and complications. **Initials:** _____

Contraindications to Treatment:

If you have a known history of the following- please notify your treatment provider, as you may not be a suitable candidate for elective IV Therapy:

- Kidney Disease or Dysfunction; Chronic Kidney Disease; Pheochromocytoma
- Liver Disease or Dysfunction
- Congestive Heart Failure

Contraindications continued on next page

Contraindications to Treatment, Continued:

- Active Dialysis
- G6PD Deficiency
- Allergies or sensitivities to any substances intended for IV administration
- Altered Mental Status or Recent Head Injury with Ongoing Symptoms or Under the Influence of Drugs/Alcohol
- Uncontrolled High Blood Pressure or High Blood Pressure with Symptoms of: Chest Pain, Vision Changes, etc.
- Diabetes Insipidus; Diabetes Mellitus (uncontrolled)
- Recent Severe Burns or Fluid Volume Sensitivities
- Clotting Factor Disorders or Polycythemia Vera
- Grave's Disease
- Leber's Hereditary Optic Nerve Disease
- Known Hyponatremia or Hypernatremia
- Myasthenia Gravis
- Currently Pregnant (depending on trimester and infusion additives)
- Peptic Ulcer Disease of Active GI Bleeding
- Parkinson's, Tardive Dyskinesia, Seizure Disorder, or Use of Certain Psychiatric Medications
- Long QT Syndrome or Unexplained Fainting

I have read and understand the above stated conditions may be contraindications for this treatment. I agree to disclose if I meet any of the above criteria and discuss treatment options with my provider: **Initials:** _____

Possible Interactions

Prescription and OTC Medication, Herbal and Nutritional Supplements, and Minerals: I understand that certain herbal products, medications, and supplements may result in reduced efficacy of treatment and/or additional side effects when interacting with substances used in IV Therapy.

I have read and understand possibility of interactions with treatment: **Initials:** _____

Maintaining Results:

For continued results, you may require additional IV Therapy treatments at intervals as determined by your treatment provider in conjuction with your personal treatment plan.

I have read and understand I may require future treatments to maintain results. **Initials:** _____

No Guarantee of Results:

In some situations, it may not be possible to achieve optimal results. Should complications occur, additional or other treatments may be necessary.

I have read and understand results are not guaranteed. **Initials:** _____

Disclosure of Health History/Medications/Substance Use:

I agree to inform the staff of any known allergies to medications, foods, and/or other substances and have disclosed any previous allergic reactions. I further agree to inform staff of any/all medications/substances I am currently taking, including recreational or street drugs, and have disclosed all pertinent health history. I understand that failing to inform the staff about my medical issues and/or drug use can lead to serious complications.

I have disclosed all medication, allergy, and health history to staff. **Initials:** _____

Medical Care:

I understand that Center for Seeking Peace is not a medical facility, nor does it provide medical diagnostics or medical care. If I feel I need medical attention and/or am concerned about a new or ongoing medical condition, I agree to seek medical attention and care at a qualified medical facility.

I have read and agree to the aforementioned medical care statement. **Initials:** _____

Consent continued on next page

Liability Release Related to Adverse Effects

I assume full liability for any adverse effects that may result from the non-negligent administration of the proposed treatment. I waive any claim in law or equity for a redress of any grievance that I may have concerning- or resulting from- the treatment, except as that claim pertains to the negligent administration of this procedure.

I agree to assume full liability for any adverse effects of treatment. **Initials:** _____

Aftercare:

I have received and will follow all verbal and/or written aftercare instructions provided. **Initials:** _____

Financial Responsibility:

By signing below, I acknowledge that I understand the regular charge applies to all treatments. I understand- and agree- that all services rendered to me are charged directly to me and that I am personally responsible for payment. I acknowledge that most insurances do not cover the cost of elective Vitamin B-12 injection treatment, and therefore, I am required to pay for services and medication out of pocket. If I am not satisfied with my results, I agree not to seek a refund for Vitamin B-12 injection treatment services rendered, as I am fully aware that there is no implied or explicit guarantee of results, as stated in the acknowledgment above. **I further agree in the event of non-payment and/or reversal of payment via a credit card dispute that I initiate, I will bear the cost of collection fees, and/or court fees, and/or any reasonable legal fees resulting from such instance.**

_____	_____	_____
Patient Name (Print)	**Patient Signature**	**Date**

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Consent continued on next page

Elective Intravenous (IV) Fluid Therapy Consent:

By signing below, I acknowledge and agree:

- I have fully disclosed on my client intake form and during face-to-face consultation with the treatment provider any medications, previous complications, planned or previous surgeries, sensitivities, allergies, or current conditions that may or may not affect my treatment.
- I have read the foregoing informed consent for IV Infusion Therapy; I agree to the treatment and all known and unknown associated risks.
- I have received and will follow all aftercare instructions.
- I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.
- **I consent to the collection of photo(s) and video(s) of the treatment to be performed, including appropriate portions of my body for: medical documentation, insurance documentation, and/or educational and training purposes. I understand that efforts will be made to conceal my identity, but in some circumstances, the photographs may portray features that will make my identity recognizable.**
- It has been explained to me in a way that I understand:
  - There may be alternative procedures, methods, or treatments.
  - There are risks, known and unknown, to the procedure or treatment proposed.
- I have had ample opportunity to ask any questions regarding IV Infusion Therapy benefits, side effects, and aftercare, and all of my questions have been answered to my satisfaction. I believe I have adequate knowledge to understand the nature and risk of the treatment to which I am consenting.
- **By signing below, I am consenting to undergo this, and any subsequent IV Infusion Therapy for 365 days from the date below,** with all aforementioned understood by me. I release the overseeing clinic physician, the person performing the IV Infusion Therapy, and the clinic facility from liability associated with treatment.

Patient Name (Print)	Patient Signature	Date

Witness Name (Print)	Witness Signature	Date

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Authorization for Collection and Use of Photography and Video for Promotional Purposes:

A) I hereby grant permission to Center for Seeking Peace to collect and distribute photo(s) and video(s) for advertising or promotion including, but not limited to: emails, newsletters, promotional materials, brochures, pamphlets, flyers, social media posts, and internet websites. I release all rights, license, and authority to any copyright or publishing claim associated with all photograph(s) and/or video(s) related to use in publication as described above; this includes any claim for payment in connection with distribution or publication of the photograph(s) and/or video(s). I understand that efforts will be made to conceal my identity, but in some circumstances, the photographs may portray features that will make my identity recognizable. I hereby waive the right to inspect or approve any photo(s) and/or video(s) collected and distributed as described above.

☐ **Yes**, I consent to the collection, use, and distribution of my before/after photo(s) and/or video(s) as described above in paragraph (A).

☐ **No,** please do not distribute my photo(s) or video(s) for any promotional or advertising purposes.

Patient Name (Print)	Patient Signature	Date

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CLIENT ACKNOWLEDGEMENT AND LIABILITY RELEASE

Treatment Liability Waiver

I acknowledge that elective supplementation therapies, including, but not limited to, Vitamin B, Nutrient, and Amino Acid Injections and IV Therapy, may be considered medically unnecessary. It may or may not mitigate, alleviate, or cure the condition for which it is prescribed. This therapy has been recommended to you in the belief that it is of potential benefit in these circumstances and its use will quite probably improve the condition for which you are under treatment and your overall health. Based on the risks and potential benefits of the current medically indicated treatment(s) and this proposed treatment, I have elected to forego or supplement the indicated treatment(s) and receive this proposed treatment from providers and staff at Center for Seeking Peace.

I understand that I may suspend or terminate my treatment at any time by informing my medical provider. I assume full liability for any adverse effects that may result from the non-negligent administration of the proposed treatment. I waive any claim in law or equity for redress of any grievance that I may have concerning or resulting from the procedure, except as that claim pertains to negligent administration of this procedure. The risks involved and the possibilities of complications have been explained to me. I fully understand and confirm that the nature and purpose of the aforementioned treatment to be provided may be considered unproven by scientific testing and peer-reviewed publications and therefore may be considered medically unnecessary or not currently indicated.

Therefore, in consideration for any treatment received, I agree to unconditionally defend, hold harmless, and release from any liability the company and the individual that provided my treatment, the insured, and any additional insureds, as well as any officers, directors, or employees of the above companies for any condition or result, known or unknown, that may arise as a consequence of any treatment that I receive.

I understand and agree that any legal action of any kind related to any treatment I receive will be limited to binding arbitration using a single arbitrator agreed to by both parties.

Covid-19 and Communicable Diseases

Acceptance of Risk; Release; Indemnification. I am fully aware that there are several risks associated with me entering the Center for Seeking Peace property during the COVID-19 pandemic under the circumstances of receiving treatments, including without limitation: (a) I could contract COVID-19 or other diseases such as the flu or legionnaires disease which could result in a serious medical condition requiring medical treatment in a hospital or could lead to death; and (b) I will be subject to normal risks associated with general exposure to viruses and other communicable diseases.

By signing below, I acknowledge and agree: I have carefully read the information on this page and understand that I may be giving up some important legal rights by signing.

Patient Name (Print)	Patient Signature	Date
Witness Name (Print)	Witness Signature	Date