CULTIVATING RESILIENCE, LLC CLINICAL POLICIES

PATIENT CONSENT FOR IV INFUSION AND INJECTION THERAPIES

If you have any questions, please feel free to ask us. Otherwise, please initial each point below acknowledging you understand that:

_____ If you are late or miss your appointment, you may be subject to a $125 fee.

_____ Services must be paid for at the time of service.

_____ Health insurance typically does not cover services provided at Cultivating Resilience, LLC. If you want to seek insurance reimbursement, we would be happy to provide you itemized invoices that you can submit to your insurance company.

_____ I understand that treatments used at Cultivating Resilience, LLC might not be considered a medical necessity. Treatments rendered are for the purpose of improving your quality of life.

_____ I agree that, if I am having any side effects or become sick, I will follow up with my primary care provider or go to an urgent care or emergency department.

_____ I acknowledge that Cultivating Resilience, LLC are not my primary care provider. I agree that I will continue with routine care through my primary care provider and notify them of treatments prescribed and performed at Cultivating Resilience, LLC.

_____ I understand that there are no refunds for services or products rendered.

_____ I understand that having an appointment with Cultivating Resilience, LLC does not necessarily entitle me to having an IV infusion or injection procedure performed. Every individual is different, and it is at the medical provider's discretion to issue treatment.

_____ I understand that I must maintain my follow-up appointments and follow post-procedural care instructions to remain on treatment. It is important that Cultivating Resilience, LLC manages my treatment and it is at their discretion to provide me ongoing therapies if desired.

_____ I acknowledge that I have been advised of the risks and benefits of treatment. I also acknowledge that I have been advised of possible complications and side effects. I understand the risks, benefits, complications, and side effects of treatment.

_____ I am voluntarily requesting treatment with Cultivating Resilience, LLC in regard to IV infusion therapy and injection therapy as determined by a mutual decision between myself and the medical provider even if it is not considered a medical necessity.

_____ I do not hold any medical practitioner of Cultivating Resilience, LLC responsible for performing age-related preventive care. I agree that I will follow up with my primary care provider to obtain these screenings and I hold Cultivating Resilience, LLC harmless if an adverse event occurs during my treatment.

I have read, understand, and agree to all of the above statements.

Print Name: _____

Signature: _____ Date:_____