Concept Chiropractic
+ Regenerative Medicine
Renew Yourself

INTRAVENOUS (IV) INFUSION THERAPY CONSENT

This document is intended to serve as informed consent for your Intravenous (IV) Infusion Therapy as ordered by the medical provider at Concept Chiropractic + Regenerative Medicine (CCRM).

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

My signature below confirms that:

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

2. Intravenous (IV) Infusion Therapy has been adequately explained to me by the CCRM provider.

3. I have received all the information and explanation I desire concerning the procedure.

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

5. I release Zohar Levites, ARNP, CRNA, Concept Chiropractic + Regenerative Medicine, 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

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Patient's Signature and Date

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CCRM Provider Name: Please Print

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CCRM Provider Name: Please Print Signature and Date

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