**Please review this form before arrival for your first appointment*

INTRAVENOUS THERAPY/INJECTION CONSENT FORM

It is very important to **Dr. Laura Ruby, DNP, CRNP, IFMCP** that you understand and consent to the treatment your provider is rendering. You should be involved in any and all discussions concerning such procedures or treatments. Sign this form only if you understand the procedure, anticipated benefits, the risks, the alternatives, and all your questions have been answered. Please sign and date directly below this paragraph indicating your understanding of this paragraph.

_____ _____

Patient's or Authorized Representative Signature Date

I, _____ Hereby give consent to **Optimal Wellness for Life** and its staff to perform intravenous vitamin and mineral therapy. I understand that intravenous nutrient therapy is not standard, widely approved or accepted within the medical community. I have been informed that these infusions have not been evaluated by the US Food and Drug Administration (FDA) and are not intended to treat, diagnose, cure, or prevent any medical disease. These infusions are not meant as a substitute for your physician's medical care. I understand that the benefits of IV nutrient therapy are much greater if I follow a healthy lifestyle (non-smoking, weight control, regular exercise, whole food diet, and nutritional supplementation), and as with any other medical procedure, a small percentage of clients do not respond to this therapy. I understand that the **alternatives** to intravenous therapy are oral supplementation and/or dietary and lifestyle changes, or no procedure or treatments.

I understand that I have the right to be informed of the procedure, any feasible alternative options, and the risks and benefits. The procedure will not be performed until I have had an opportunity to receive such information and to give my informed consent. I understand that I have the right to consent or to 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 therapy with any different or further procedures, which, in the opinion of my healthcare provider, may be indicated.

I understand that the **procedure** involves:

a. Insertion of a needle into a vein and infusing the prescribed solution
b. Infusion of prescribed solutions over a safe period of time, which may vary depending on solution infused
c. Optimal Wellness for Life has taken every measure possible to ensure safety of infusions and procedures and maintenance of aseptic technique.

I understand the **risks** of intravenous infusions include but are not limited to:

a. Discomfort, bruising and pain at the injection site. Rarely: inflammation or clot within the vein used for injection called phlebitis or thrombophlebitis
b. Rarely: fatigue, allergic reaction, congestive heart failure, lowering of blood sugar levels, fever, chills, generalized complaints.
c. Extremely rare: severe allergic reaction, anaphylaxis, cardiac arrest and death.

I understand the **benefits** of intravenous therapy include:

a. Injectables are not affected by the stomach, or intestinal absorption problems
b. The total amount of the infusion is available to the tissues.
c. Nutrients are forced into cells by means of a higher concentration gradient.

d. Higher doses of nutrients can be given that is possible by mouth without intestinal irritation.

I have informed my healthcare provider of any known allergies to drugs or other substances, or of any past reactions to anesthetics. I have informed the provider of all current medications and supplements. I have fully informed the nurse and/or provider of my medical history.

_____ I am aware that other unforeseeable complications could occur. My medical provider has explained these risks to me as well as other treatment options including receiving no treatment and the possible outcomes. I understand the risks and benefits of the procedure and I have had the opportunity to have all of my questions answered.

_____ While I understand that there have been no warranties or guarantees of successful treatment made to me, I desire to undergo this treatment after having considered the information contained in this document, the information provided to me through verbal conversations and/or educational materials that have been made available to me. I acknowledge that I have had the opportunity to ask questions and with respect to my proposed therapy and treatments and that questions have been answered to my satisfaction.

_____ My signature on this agreement will constitute a full and final release of any legal responsibility resulting from the administration of intravenous nutrient therapy in my case and/or any other medical treatments that may be necessary as a result thereof. I release Dr. Laura Ruby, Optimal Wellness for Life, and all the medical staff from all liabilities for any complications or damages associated with my intravenous infusion therapy.

My signature below confirms that:

a. I understand and agree to the information provided on this form.
b. The procedures to be performed have been adequately explained to me by my provider or nursing staff.
c. I have received all the information and explanation and desire to proceed with my infusion procedure(s).
d. I authorize consent to the performance of the procedure(s).

_____	_____	_____	_____
Date	Time	Signature of Patient	Printed Name of Patient
_____	_____	_____	_____
Date	Time	Signature of Witness	Printed Name of Witness
_____	_____	_____	_____
Date	Time	Signature of Provider	Printed Name of Provider