Informed Consent for Intravenous (IV) Therapy

Please initial below next to the appropriate statement depending on which classification of IV therapy pertains to you:

IV Wellness Therapy at FoRM Consent:_____ (initial here to agree to the following statement)
I am consenting to receive IV Therapy at FoRM for purposes of supporting ***general wellness***. I acknowledge that the IV Wellness formulas are not intended to treat or address any underlying medical condition. ***I affirm that I am a healthy individual, without an underlying chronic condition or diagnosis***. I am selecting the IV therapy formula that I believe works best for my goals.

IV Medical Therapy at FoRM Consent: _____ (initial here to agree to the following statement)
I am consenting to receive IV Therapy at FoRM for purposes of addressing symptoms associated with a specific ***medical diagnosis or condition*** and I understand that IV therapy doesn't constitute treatment for any particular medical condition. Prior to receiving IV therapy I understand and agree to an office visit with the IV-performing provider and any blood work (within 1 year) that provider finds to be necessary before starting IV therapy. I understand that IV Medical Therapy at FoRM is physician-directed and includes any of the following IV options: *IV Ozone/MAH, Iron infusions, High Dose Vitamin C* (up to 25grams), *NAD+ IV and any Custom Formulation.*

General Consent:
In addition to full disclosure of my medical history, I have recounted a complete history of all known allergies. I understand that this treatment involves inserting a needle and injecting a formula of approved substances into my veins or muscle. I realize that there may be some discomfort at the site of treatment and that it is my responsibility to inform the physician of any burning, pain, or negative reaction I may be experiencing. During IV treatment, it is possible for the injection fluid to leak out of the vein into the surrounding tissue. I understand that although the infiltrated fluid may cause pain, it is not dangerous to my health and my body will absorb the fluid. I realize that during and after my treatment I may experience temporary discomfort at the site of treatment. In the rare case of a severe allergic reaction, emergency medical care may be required.

I understand that there is no implied or stated guarantee of success or effectiveness of any specific treatment. I understand that I am free to withdraw my consent and to discontinue participation in these treatments at any time. I understand that, except in emergencies, I must give 24 hours notice of intent to cancel or reschedule my appointment.

Financial policy regarding IV packages:
I understand that ***IV packages are non-refundable*** once purchased, however they may be transferred to another individual who is an established patient of FoRM. Packages must be pre-paid by the time of service in order to receive any discount. No discount will be offered on IV services rendered individually.

Furthermore, ***I elect to pay out of pocket for all intravenous infusions*** received at FoRM. I will not attempt to bill my insurance for these services, and I understand FoRM health will not provide superbills for the purpose of billing insurance. By electing to self-pay for these services, I understand that these payments will not go towards satisfying any deductible or out of pocket maximum and I will not submit claims to be billed retroactively.

Advantages of IV Therapy	*Disadvantages of IV Therapy*
- Total amount given is immediately available to tissues by means of a high solution concentration helping to force nutrients into cells. - Given doses of nutrients higher than those possible by mouth without intestinal irritation - Not affected by digestive process or intestinal disease.	- Pain, bruising, and rarely infection at injection site. - Inflammation of vein used for infusion, phlebitis - Severe allergic reaction or anaphylaxis, resulting in cardiac arrest, possibly death *Alternatives to IV therapy* - oral supplementation, lifestyle + dietary changes

I have read this form and have had the opportunity to ask questions regarding the content of this form.
I authorize the physicians at FoRM Health, LLC to administer intravenous therapy.

Printed Name:_____ Signature:_____Date:_____