INTRAVENOUS THERAPY CONSENT FORM

This Document is intended to serve as confirmation of informed consent for IV therapy as ordered by my physician at ElLEMENT 7 WELLNESS.

(Initials) _____ I have informed my physician of any known allergies to drugs or others substances, or of any past reaction to anesthetics. I have informed the doctor of all current medications and supplements.

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.

I understand that:

a. The procedure involves inserting a needle into a vein and injecting the prescribed solution.

b. Alternatives to intravenous therapy are oral supplementation and / or dietary and lifestyle changes.

c. Risks of intravenous therapy include:

i. Occasionally to commonly: Discomfort, bruising and pain at the injection site.

ii. Rarely: Inflammation of the vein used for injection called phlebitis.

iii. Extremely Rarely: Severe allergic reaction, anaphylaxis, cardiac arrest and death

d. Benefits of intravenous therapy include:

i. Injectables are not affected by the stomach, or intestinal absorption problems.

ii. The total amount of the infusion is available to the tissues.

iii. Nutrients are forced into cells by means of a higher concentration gradient.

iv. Higher doses of nutrients can be given than is possible by mouth without intestinal irritation.

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

I understand that I have the right to consent to or to refuse any proposed treatment at any time prior to it's 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 physician, may be indicated.

"Chelation Therapy" is a term used in conjunction with IV nutrient therapy. If you are receiving IV therapy for detoxification, and - or the treatment of heavy metals in your body then your therapy may include a chelating substance, such as EDTA or DMPS along with specific nutrients. Any use of chelation outside of those boundaries is outside of the scope of Washington State law, and will not be offered in this clinic.

My signature below confirms that:

a. I understand the information provided on this form and agree to the foregoing.

b. The procedures set forth above have been adequately explained to me by my physician.

c. I have received all the information and explanation I desire concerning the procedures.

d. I authorize and consent to the performance of the procedure(s).

_____

Patient's Name - Please Print Date

_____

Patient's Signature Date

_____

Physician's Name - Print Date

_____

Physician's Signature Date