**PATIENT DEMOGRAPHICS & INFORMED CONSENT FOR IV HYDRATION THERAPY SERVICES**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle one: MALE / FEMALE Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications and Current Dosage (Including all prescription, over the counter, herbs, vitamins, and supplements): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you been hospitalized or under the care of a physician in the past month? \_\_\_\_\_\_YES \_\_\_\_\_\_NO

2. Medical History: Congestive Heart Failure \_\_\_\_\_\_YES \_\_\_\_\_\_NO

Liver Disease \_\_\_\_\_\_YES \_\_\_\_\_\_NO

Kidney Disease or Renal Insufficiency \_\_\_\_\_\_YES \_\_\_\_\_\_NO

Gastrointestinal bleeding \_\_\_\_\_\_YES \_\_\_\_\_\_NO

3. Do you currently take a blood thinner? \_\_\_\_\_\_YES \_\_\_\_\_\_NO

4. Do you currently take or use any type of steroid? \_\_\_\_\_\_YES \_\_\_\_\_\_NO

5. For Females: Are you pregnant? \_\_\_\_\_YES \_\_\_\_\_NO Date of last menstruation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE INITIAL BELOW**:

If you answered (“Yes”) to any of the above questions 1-5, it may be advised by the Medical Director that you not receive IV Fluids, and you may be denied services. \_\_\_\_\_\_\_\_\_\_

I understand that participating in the intravenous (IV) hydration and vitamin administration services provided by Infinity Wellness carries risks. \_\_\_\_\_\_\_\_\_\_

I have truthfully answered all questions regarding my medical history and have informed the staff about any and all prescription medications and/or over the counter drugs I take, as well as any street or recreational drugs. I understand that failing to inform the staff about my medical issues and/or drug use can lead to serious complications. \_\_\_\_\_\_\_\_\_\_

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 provider’s medical care.\_\_\_\_\_\_\_\_\_\_

I acknowledge that I am responsible for any medical care I may have that is directly or indirectly related to the services provided by Infinity Wellness. If I seek medical treatment for any side effect or reaction, it will be at my own expense. \_\_\_\_\_\_\_\_\_

I acknowledge and agree that the sole risk of injury or harm resulting in any manner from my voluntary participation in Infinity Wellness’s services rests entirely with me to the extent that I fail to disclose my health condition(s), medications, or drug use in advance of the services provided. \_\_\_\_\_\_\_\_\_\_

I expressly represent and warrant to Infinity Wellness that I have never been diagnosed with or treated for any illnesses or conditions that may result in increased risk when participating in the services provided by Infinity Wellness. I understand that Infinity Wellness bears no responsibility for and will not screen for, diagnose, monitor, or provide any care for such conditions. \_\_\_\_\_\_\_\_\_\_

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, lightheadedness or fainting. 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. \_\_\_\_\_\_\_\_\_\_

I acknowledge that I have been given the opportunity to discuss the nature and purpose of the treatment and the risks, complications, and consequences associated with the procedures. I am aware that it is impossible to foresee or predict all possible risks, complications, and consequences, and I do not expect that the staff to anticipate or explain all associated risks. \_\_\_\_\_\_\_\_\_\_

I waive any and all claims related to the services provided and agree to hold Infinity Wellness harmless regarding any complications or consequences I experience during or following the service. \_\_\_\_\_\_\_\_\_\_

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***SIGNATURE PAGE** \*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

My signature below confirms that: I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. I authorize and consent to the use of hydration therapy. The procedure set forth above has been adequately explained to me by my attending medical professional. I have received all of the information that I desire regarding hydration therapy. This document services as an informed consent for hydration therapy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Signature/Credentials Date

**Infinity** **Wellness- 1558 Airport Rd St E. – Hot Springs, AR 71913 - Phone: (501) 701-9395**