Vitruvia IV Lounge

Date: _____

Patient name: _____

Date of birth: _____ **Sex**: _____ **Phone** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

E-mail: _____

Please initial the following:

_____ By initialing you are acknowledging you are an exclusive patient of the IV Lounge only. You will be screened to make sure you don't have any contraindications for IV therapy or injections only. Dr. Miles will NOT make medical recommendations for any medical issues you have and you must continue care with your primary care physician. No medications should be discontinued just because you are doing IV/IM therapies.

_____ By initialing you are giving consent to receive Dr. Miles newsletters and emails which provides you information on top medical topics and specials.

Emergency Contact: _____ **Relationship:** _____

Phone number of Emergency Contact: _____

Signature: _____

Date: _____

Patient: _____ **Date or birth**: _____ **Sex**: _____

Primary care physician: _____

Current health concerns: _____

Are you allergic to the following? Please put an X if you are…

_____ Shellfish _____ Latex _____Iodine _____ Tapioca reactions: _____

Allergies to medications: please list the medication and the reaction-

_____ _____

_____ _____

Current Medications:

_____ _____ _____

_____ _____ _____

Past Medical History – Have you ever been diagnosed with:

_____ High blood pressure _____ Angina _____ Ankle swelling

_____ Abnormal EKG _____ Congestive Heart Failure _____ Arrhythmia (irregular heart beat)

_____ Heart attack _____ Kidney disease _____ Bleeding disorder

_____ Asthma _____ Lung problems _____ Diabetes

_____ Anxiety or panic attacks _____ Iron loading disorder _____ Sickle cell

_____Other : explain _____

_____

Past Surgical History – please list any surgeries you have had

_____ _____

_____ _____

_____ _____

Have you been treated or are you undergoing treatment for cancer? Please Describe

_____

Patient Signature: _____

IV Lounge consent Date: _____

Name of Patient: _____ Date of Birth: _____

Procedure(s): IM injections and IV Nutrients including but not limited to IV vitamin C, Myer's cocktail, and glutathione

1. Vitruvia provides facilities and personnel to assist you in the performance of intravenous therapy. You 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 you have had an opportunity to receive such information and to give your informed consent.

a. The procedure involves inserting a needle into your vein or muscle and injecting the formula described above.

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

c. Risks of intravenous therapy include:

i. Discomfort, bruising and pain at the site of injection.

ii. Inflammation of the vein used for injection may cause phlebitis or sclerosis (closure of vein)

iii. Severe allergic reaction, anaphylaxis, cardiac arrest and death.

d. Benefits of intravenous therapy include:

i. Injectables are not affected by stomach or intestinal disease.

ii. Total amount of infusion is available to the tissues.

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

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

2. You have the right to consent to or refuse and proposed treatment at any time prior to its performance. Your signature on this form affirms that you have given your consent to the procedure(s) described above with any different or further procedures which, in the opinion of your physician, may be indicated.

3. The procedure will be performed under the direction of Dr. Laura Miles MD with qualified medical assistants and nursing staff.

4. I understand that if my medical condition changes from the time of this initial authorization form that it is my responsibility to inform Dr. Miles staff before having an IV/IM injection. (new allergies, new medications, new medical issues)

5. I acknowledge the treatments are not covered by insurance and will not be reimbursed for these services.

Your signature below means that:

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

b. The procedure(s) set forth above has been adequately explained to you.

c. You have received all the information and explanation you desire concerning the procedure.

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

I _____ enter into this contract willingly and understand fully the terms of this agreement.

I also understand that these therapies are not a cure and I should continue all medical therapies.

Patient/Representative Signature: _____ Witness: _____

If signed by representative, indicate relationship: _____ Date: _____