Name: _____ Date: _____

IV Treatment Consent Form

I, _____ give the provider at YOUnique Health & Wellness consent to administer IV infusion of NAD, Chelation, Ketamine or Vitamin therapy. We have discussed the benefits and risks to IV therapy. I understand that IV therapy is not evaluated by the FDA and these treatments are not intended to diagnose, treat, cure, or prevent disease.

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 to commonly: i. Discomfort, bruising and pain at the site of injection.
   b. Rarely: i. Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury.
   c. Extremely Rarely: i. Severe allergic reaction, anaphylaxis, infection, cardiac arrest, and death.
   d. Benefits of intravenous therapy include:
      i. Injectables are not affected by stomach, or intestinal absorption problems.
      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.

I am aware that other unforeseeable complications could occur. I do not expect the physician(s)/nurse practitioner to anticipate and or explain all risk and possible complications. I rely on the physician(s)/nurse practitioner to exercise judgment during treatment with regards to my procedure. I understand the risks and benefits of the procedure and have had the opportunity to have all my questions answered. I understand that I have the right to consent to or 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 physician(s)/nurse practitioner or other associated with this practice, may be indicated.

My signature below confirms that:

1. I understand the information provided on this form and agree to the foregoing.
2. The procedure(s) set forth above has been adequately explained to me by my physician/nurse practitioner.
3. I have received all the information and explanation I desire concerning the procedure.
4. I authorize and consent to the performance of the procedure(s). **IV NAD+ Infusion and/or Vit IV Therapy**

PatientSignature_____ **Date**: _____

Provider Signature: _____ **Date**: _____

*Disclaimer – NAD+ qualifies as a supplement under FDA guidelines. These statements have not been evaluated by the Food and Drug Administration. Intravenous NAD+ therapy is not intended to diagnose, treat, cure, or prevent any disease.