NEW IMAGE HEALTH & WELLNESS

IV INFUSION / IM / SQ INJECTION INFORMED CONSENT

Client Information

First Name: _____

Last Name: _____

Date of Birth: _____

Phone: _____

Email: _____

Address: _____

Preferred Contact Method: _____

Consent and Acknowledgement
I understand that IV infusion and injection therapy at New Image Health & Wellness is not intended to diagnose, treat, cure, or prevent any disease or medical condition. I understand that IV infusion therapy involves inserting a peripheral intravenous catheter into a vein and administering fluids, vitamins, minerals, nutrients, and/or medications directly into the bloodstream. Injection therapy involves administering vitamins, minerals, nutrients, and/or medications into muscle tissue (IM) or subcutaneous tissue (SQ). I have disclosed all medications, supplements, medical conditions, and allergies. I understand serious adverse events may occur if I fail to disclose this information. I understand these therapies and any related claims have not been evaluated by the FDA for the diagnosis, treatment, cure, or prevention of disease and are considered elective wellness therapies.

Potential Benefits
• Increased hydration
• Improved nutrient availability
• Symptom support and wellness optimization
• Recovery and performance support

Potential Risks
Common risks include pain, bruising, irritation, discomfort, and bleeding at the injection or IV site. Less common risks include infection, tissue injury, phlebitis, low blood pressure, fainting, fluid overload, medication interactions, allergic reactions, and changes in blood sugar levels. I understand unforeseen complications may occur whenever an IV catheter is placed or injectable therapies are administered.

Voluntary Nature of Treatment
Treatment is completely voluntary. Alternative options may include care from my primary care provider, specialist consultation, oral supplementation, dietary modifications, lifestyle changes, or no treatment. I understand I may refuse treatment or discontinue treatment at any time.

FINAL PATIENT CONSENT

I acknowledge that: • The procedure, risks, benefits, side effects, alternatives, and expected outcomes have been explained to me.
• I have had the opportunity to ask questions and all questions have been answered to my satisfaction.
• No guarantees regarding treatment results have been made.
• I consent to emergency intervention if medically necessary during treatment.
• I am of sound mind and capable of making healthcare decisions.
• I will remain under the care of a licensed primary care provider and/or mental health provider as appropriate.
• I voluntarily consent to IV infusion therapy and/or injectable therapy provided by New Image Health & Wellness.

Client Signature: _____

Printed Name: _____

Date: _____

Provider/Witness Signature: _____

Date: _____