NEW IMAGE HEALTH & WELLNESS
CONSENT FOR BLOOD DRAW / VENIPUNCTURE

Patient Information

First Name: _____

Last Name: _____

Date of Birth: _____

Phone Number: _____

Email: _____

Address: _____

Preferred Contact Method: _____

I hereby authorize New Image Health & Wellness and its licensed medical providers and trained clinical staff to perform a venipuncture (blood draw) for the purpose of laboratory testing, diagnostic evaluation, wellness screening, IV therapy assessment, IV ozone therapy assessment, hormone evaluation, weight loss treatment monitoring, or other medically indicated services. I understand the procedure involves inserting a needle into a vein, typically in the arm, to obtain a blood sample.

I acknowledge and understand the following:
• The procedure has been explained to me in terms I understand.
• I have had the opportunity to ask questions, and all questions have been answered satisfactorily.
• Potential risks may include mild discomfort, bruising, bleeding, swelling, infection, lightheadedness, dizziness, or fainting.
• I have disclosed any relevant medical conditions including bleeding disorders, history of fainting with blood draws, pregnancy status, allergies, or medications such as blood thinners.
• I understand that while complications are rare, no guarantees have been made regarding outcomes.
• I understand that I may withdraw my consent at any time prior to the procedure.

By signing below, I voluntarily consent to the blood draw and authorize the release of laboratory results to my healthcare provider at New Image Health & Wellness for medical review and treatment planning.

Patient Signature: _____

Printed Name: _____

Date: _____

Staff/Witness Name: _____

Staff Signature: ____

Date: _____________________