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INFORMED CONSENT FOR INTRAVENOUS NUTRIENT THERAPY

I _____ hereby give consent to Dr Jennifer Gentry or her employees or staff to perform intravenous vitamin and mineral therapy for the purpose of _____. I understand that intravenous nutrient therapy is not a standard, widely approved or accepted treatment for this/these purposes and intravenous nutrient therapy is considered experimental my most physicians. Intravenous nutrient therapy will not be covered by my insurance plan, and I am expected to pay for these services personally. I am advised that my treating physician believes that other treatment approaches have been used in these conditions, including but not limited to prescription medications, over the counter drugs and these alternatives have been explained to me to my full satisfaction.

I understand that the benefits of intravenous nutrient therapy are much greater if I follow a healthy lifestyle (non-smoking, weight control, proper exercise, proper diet and nutritional supplementations). I understand that an initial series of treatment are anticipated and that these treatments may extend over a number of months. I understand that it is my option to stop at any time with this treatment protocol without incurring any further expense after I have directed that such treatment be stopped. As with any other medical procedure, a small percentage of patients do not respond to this therapy.

I have been informed of possible risks and side effects including but not limited to discomfort at the injection site, thrombophlebitis, fatigue, allergic reaction, congestive heart failure, lowering of blood sugar levels, fever, chills, and generalized complaints. I understand that this therapy should not be used if I am pregnant unless I have severe life threatening disease. I understand the nature of the proposed procedure and the risk and dangers have been explained to me to my full satisfaction.

While I understand that there have been no warranties or guarantees of successful treatment made to me, I desire to undergo this treatment after having considered the information contained in this document the information provided to me through conversations with my treating physician and through material provided to me by the office to educate me about treatment. I acknowledge that I have had the opportunity to ask any questions of my physician with respect to the proposed therapy and the procedures to be utilized and all my questions have been answered to my full satisfaction. My signature on this agreement will constitute full and final release of any legal responsibility resulting from the administration of intravenous nutrient therapy in my case or and other medical treatments that may be necessary as a result thereof.

_____ _____

Patient Name (Print) Date

_____

Patient Name (Signature)