Integrative Medical Associates

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CONSENT FORM FOR IV TREATMENT

A nutritional IV treatment has been recommended and ordered by your physician. To assure a complete understanding between doctor and patient, we have provided this form to supplement the informed consent procedures of this office.

In accepting an IV at this office, I understand the following:

1. No significant toxicities or serious adverse effects have been associated with any of the therapies that are provided at this office. However, there are mild side effects and responses from the IV therapy such as extravasation (leakage of IV content into soft tissues), vein pain and inflammation, brain fog, fatigue, weakness, nausea, lightheadedness, headaches and flu-like symptoms. Some of these effects are related to the detoxification process and some of them may be sensitivities to the supplement ingredients in unusually sensitive patients.

2. I understand it is impossible to inform me of every possible undesirable effect experienced by every patient. However, I also understand if I do experience any unexpected responses to the treatment, I may stop the treatment at any time and call my doctor at the office at the earliest opportunity to obtain further recommendations.

3. I am aware that the practice of medicine is not an exact science. I acknowledge that no guarantees have been made to me concerning either the benefits or effectiveness of the treatment. I understand that my health may not improve despite all my treatment, including the treatment provided by this office. No promises, implied and explicit, have been stated to me regarding the treatment of my condition. I have only been offered the promise that my doctor will do his/her utmost to provide me with the best complementary and nutritional therapy available to support my body and health.

4. All patients should have a hospital-based primary doctor who can assist them with any health issues occurring on the weekends or after hours. The doctors at this office are primarily consultative doctors and do not provide coverage during off-hours. Generally, the nutritional treatments recommended do not interfere with any pharmaceuticals another physician may consider necessary. Patients should inform and consult with their primary doctors regarding therapy they receive at this office for coordination of patient care.

5. My physician has personally discussed the material factors, including risk and benefits that are specific to my decision to proceed with nutritional support and detoxification treatment and all my questions regarding my treatments have been answered and explained in full, to the best of the doctor's abilities.

6. I have been given the opportunity to read information regarding the education, experience and credentials of the physicians at this office regarding the alternative and/or complementary medicine they practice.

7. I understand that the therapy recommended to me at this office may not be understood, appreciated or recommended by insurance companies, regulatory agencies or conventional physicians. Much of it may be described by them as 'not standard of care', 'unproven', 'unorthodox', 'experimental', 'not published in peer-reviewed medicine journals' or a 'waste of money'.

8. Although my doctor may suggest a protocol of treatment to me, I may refuse to follow it. Additionally, I may terminate my treatment at any time or for any reasons that I may choose with no penalties. I

understand that I will not be expected to pay for any service that I do not actually receive and that I may discontinue therapy with no financial obligation other than for services that I have already received.

9. I understand that my treatment program is on a fee-for-service basis and that I will be personally responsible for payment of all charges, regardless of insurance coverage, which may or may not reimburse me. I understand I should not assume medical insurance coverage for any of the testing or treatments my physician may order nor the consultations and examinations my physician may perform. I understand this office recommends that if I have any questions about my medical coverage I should consult my insurance company prior to receipt of services. I also understand that if any additional medical expenses including hospitalization become necessary for adequate treatment of my condition that I will personally be responsible for any such additional expenses.

10. I understand that if I purchase a discounted IV Package, if I cancel or am recommended to discontinue for any reason, the discounted amount will be null and the full amount will apply to all previous IV’s. This amount will be deducted from the amount remaining for the package and will be refunded to the patient via the same method as payment was rendered at time of package inception.

I have read and understand the above consent policy on IV treatment.

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_