HARBOR **HEALTH**
AND APOTHECARY

CELL CODE **IV HYDRATE**

DATE _____

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Date of Birth _____ Age _____ Sex _____

Email _____

How did you hear about us? ◯ Internet ◯ Facebook ◯ Friend

Emergency Contact Name & Number _____

At the time of IV Drip or Injectable order, there is a $75.00 non-refundable deposit payable via credit card. Patient acknowledges that IV product is premade and has a limited shelf life.

Patient Credit Card Number _____ Expiration _____ CCV _____

Please tell us your main complaints:
(Check all that apply)

- ◯ Fatigue or low energy
- ◯ Stress
- ◯ Poor diet due to busy lifestyle
- ◯ Brain fog or trouble concentrating
- ◯ Low mood or depression
- ◯ Headaches/migraines
- ◯ Weight gain or difficulty losing weight
- ◯ Slow metabolism
- ◯ Asthma and allergies
- ◯ Recent surgical procedure
- ◯ Recent illness
- ◯ Cold or flu symptoms
- ◯ Facial wrinkles or fine lines
- ◯ Dull or dry skin
- ◯ Malabsorption issues
- ◯ Other _____

Which statement best describes why you are seeking our services? (Check all that apply)

- ◯ I want more energy and to feel better overall
- ◯ I want to do everything I can to nourish my body
- ◯ I want to do everything I can to enhance my weight loss efforts
- ◯ I want to prevent getting sick
- ◯ I want to recover quickly from surgery or illness
- ◯ I want to slow down the aging process
- ◯ I want to feel and look younger
- ◯ I want to have smoother, brighter, and more vibrant skin
- ◯ Other _____

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MEDICAL HISTORY

Please list ALL medications and food **ALLERGIES** below:

_____

_____

_____

Have you ever been told that you have abnormal lab results?
(Check all that apply)

- ◯ Hypermagnesemia (high magnesium)
- ◯ Hypercalcemia (high calcium)
- ◯ Hypokalemia (low potassium)
- ◯ Hemochromatosis (high iron)
- ◯ Other _____

Are you pregnant?	◯ Yes	◯ No
Are you breastfeeding?	◯ Yes	◯ No
Are you diabetic?	◯ Yes	◯ No
Are you a smoker?	◯ Yes	◯ No
Do you consume more than 2 glasses of alcohol per day?	◯ Yes	◯ No

Please list ALL medications and supplements you are currently taking (prescriptions, herbal/natural, or topical):

_____

_____

_____

Do you have any of the following conditions?
(Check all that apply)

- ◯ Blood pressure problems (high or low)
- ◯ Heart attack
- ◯ Atrial fibrillation or any heart arrythmias
- ◯ Stroke or “mini stroke”
- ◯ Kidney stones
- ◯ Kidney disease/failure
- ◯ Asthma
- ◯ Optic nerve atrophy or Leber’s Disease
- ◯ Sickle Cell Anemia
- ◯ G6PD Deficiency
- ◯ MTHFR Deficiency
- ◯ Sarcoidosis
- ◯ Parathyroid problems
- ◯ Liver disease or Liver problems
- ◯ Congestive heart Failure
- ◯ QT syndrome
- ◯ Maple Syrup Urine Disease
- ◯ Lou Gehrig’s Disease
- ◯ Iron Overload (Hemochromatosis)
- ◯ Other conditions not listed:

_____

_____

_____

_____

_____

_____

_____

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COVID-19 QUESTIONAIRRE

Have you had a fever (temperature >100.5F), chills, or body aches in the last 48 hours? ◯ Yes ◯ No

Have you had a positive COVID-19 test? ◯ Yes ◯ No

If so, when?

_____

_____

Have you been in close contact or had a high-risk encounter (unmasked greater than 15 minutes, less than 6 feet apart) with anyone who has COVID-19 in the past 48 hours? ◯ Yes ◯ No

This procedure may be considered medically unnecessary. It may or may not mitigate, alleviate, or cure the condition for which it has been prescribed. This therapy has been recommended to you in the belief this is of potential benefit in these circumstances and its use will quite probably improve the condition for which you are under treatment and in your overall health.

Based on the risk and potential benefits of the current medically indicated treatment(s) and of this proposed treatment, I have elected to forego or supplement the indicated treatment(s) and receive this proposed treatment from the nurse practitioners and other health professionals at Harbor Health, LLC, as is appropriate and necessary for my care.

I understand that I may suspend or terminate my treatment at any time by informing my medical provider. I assume full liability for any adverse effects that may result from the non-negligent administration of the proposed treatment to the fullest extent allowed by the law. I waive any claim in law or equity for redress of any grievance that I may have concerning or resulting from the procedure, except as that claim pertains to negligent administration of this procedure. The risks involved and the possibilities of complications have been explained to me. I fully understand and confirm that the nature and purpose of the aforementioned treatment to be provided may be considered unproven by scientific testing and peer-reviewed publications and therefore may be considered medically unnecessary or not currently indicated.

I herby place myself under your care for intravenous vitamin and/or hydration therapy and agree to the above release. I also verify that all information presented to you in my medical history is true to the best of my knowledge. I am not misrepresenting myself and I place myself under your care for the sole purpose of treatment for these conditions.

I hereby acknowledge that I understand that my insurance coverage, including Medicare, will not be billed and will not pay for this Non-covered service, and that all services ancillary to this treatment will also be Non-covered services and Non-reimbursable. I agree to be responsible for payment.

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INFORMED CONSENT

This document is intended to serve as informed consent for your Intravenous (IV) Infusion Therapy or your Intramuscular Injection(s) as prescribed by the medical staff at Harbor Health, LLC. You will need to sign after reading below.

I have informed the nurse practitioners or nurse of any known allergies to medications or other substances and of all current medications and supplements. I have fully informed the staff of my complete medical history.

Intravenous Infusion Therapy and any claims made about these infusions have not been evaluated by the US Food and Drug Administration and are not intended to diagnose, treat, cure, or prevent medical disease. These IV infusions are not a substitute for your physician's medical care.

I understand that I have the right to be informed of the procedure, any feasible alternative options, and the risks and benefits. Except in emergencies, procedures are not preformed until I have had an opportunity to receive such information and to give my informed consent.

I understand the following:

1. The procedure involves inserting a needle into the vein and injecting the prescribed solution. Intramuscular injections involve inserting a needle into a large muscle and injecting the solution.
2. Alternatives to intravenous therapy are oral supplementation and/or dietary and lifestyle changes.
3. Risks of intravenous therapy include but are not limited to:
    a) Occasionally: Discomfort, pain, and burning at the site of the injection.
    b) Rarely: inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury.
    c) Extremely Rare: Severe allergic reaction, anaphylaxis, cardiac arrest, death, air embolism, fluid overload, medication adverse interactions, and nerve injuries.
4. Benefits of intravenous therapy include:
    a) Injectables are not affected by stomach or intestinal absorption problems.
    b) Total amount of the infusion is available to tissues.
    c) Nutrients are forced into cells by means of high concentration gradient.
    d) 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 nurse practitioners, nurses, and or physician to anticipate and or explain all the risks and possible complications. I rely on the nurse practitioners, nurses and or physician to exercise judgment during the course of treatment with regards to my procedure. I understand the risks and benefits of the procedure and have had the opportunity to have all of 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.

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My signature on this form affirms that I have given my consent to IV Infusion Therapy including any other procedure which, in the opinion of my health care provider may be indicated. My signature below confirms that:

1. I understand the information provided on this form and agree to all the statements made above.
2. Intravenous (IV) Infusion Therapy has been adequately explained to me by the provider at Harbor Health.
3. I have received all the information and explanation I desire concerning the procedure.
4. I authorize and consent to the performance of Intravenous (IV) Infusion Therapy.
5. release Cynthia Helgeson, ARNP, Harbor Health LLC, and all the medical staff from all liabilities, complications, or damages associated with Intravenous (IV) Infusion Therapy.

WARNING!

I EXPRESSLY REPRESENT AND WARRANT TO HARBOR HEALTH, LLC THAT I AM NOT A USER OF ILLEGAL DRUGS AND/OR CONTROLLED SUBSTANCES (OTHER THAN THOSE LAWFULLY PRESCRIBED TO ME AND TO WHICH I HAVE FULLY DISCOLSED TO HARBOR HEALTH, LLC) AND AM NOT UNDER THE INFLUENCE OF SAME OR RECOVERING FROM USE OF SAME AT THE TIME OF THE PROVISION OF SERVICES TO YOU.

IN THE EVENT OF AN EMERGENCY, CALL 911 OR PROCEED TO THE NEAREST EMERGENCY ROOM.

ACKNOWLEDGMENT: I confirm that I have read this form and fully understand its contents. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the sessions and programs offered Harbor Health, LLC. I understand the nature of the sessions and programs and that participating in them carries risks. I have been given an opportunity to ask questions, and all of my questions have been answered fully and to my satisfaction. I agree to my assumption of all risks associated with my participation.

Medical Professional Certification. I hereby certify that I have explained the nature, purpose, benefits, risks of, complications from, alternatives to (including no participation by the client and any attendant risks), the proposed regimen, sessions, and programs, have offered to answer any questions and have fully answered all such questions. I believe that the client/agent/relative/guardian fully understands what I have explained.

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DISCHARGE INSTRUCTIONS FOR INTRAVENOUS (IV) INFUSION THERAPY

How to care for yourself after your IV infusion:

- Apply pressure to site for 2 minutes after IV has been removed
- Keep Band Aid in place for 1 hour
- Warm packs and elevating your arm can be used for any bruising at the site
- Cold packs can be used for pain relief and to decrease any swelling at the site
- Any swelling should be significantly reduced in 24 hours
- Post IV infusion symptoms are uncommon

Most patients experience significant overall improvements:

- Better energy
- Better mental clarity
- Improved sleep
- Overall sense of wellbeing

Patients commonly report one of two patterns after an IV Vitamin Infusion:
Patients generally feel better right away. Due to a busy lifestyle, many people are chronically dehydrated and deficient in vitamins and minerals causing them not to feel well. Once the patient is hydrated and the nutrients are replaced, their symptoms improve quickly.

Patients sometimes feel unwell or tired. These patients are generally in the process of detoxifying. When toxins are pulled out of tissues, they re-enter the bloodstream. They remain poisons, but are now on their way **OUT** instead of on their way **IN**. Even when patients do not feel well at this stage, the process is one of healing and cleansing. After this period, an overall improvement in one's sense of wellbeing is generally reported.

Please contact Cynthia Helgeson, ARNP, if you experience any symptoms, you are not comfortable with.
If any of the following are progressively worsening after your IV infusion:

- Significant swelling over the IV site
- Redness over the vein that is increasing in size
- Pain in the vein/arm that is not improving over an 8–12-hour period
- Headache that does not resolve with increased hydration or over-the-counter pain relievers such as Advil or Tylenol

IF YOU FEEL LIKE YOU ARE HAVING A LIFE-THREATENING EMERGENCY, PLEASE CALL 911

Print Name _____ Date _____

Participant's Signature _____