ENHANCED WELLNESS *of* NEW MEXICO
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CONSENT *for* INTRAVENOUS (IV) INFUSION THERAPY

I, _____, hereby authorize Dr. Joseph Jaros and/or Dr. Jan Jay and their staff to treat me using intravenous therapy. I have shared with Dr. Jaros and/or Dr. Jay any known allergies that I may have. I understand that this treatment involves inserting a needle and injecting a standardized formula into my veins or muscles. I realize that there may be some discomfort at the sites of treatment and that it is my responsibility to inform Dr. Jaros and/or Dr. Jay or her staff of any burning, pain, or negative reactions I may be experiencing. During intravenous treatment, it is possible for the injection fluid to leak out of the vein into the surrounding tissue. If I feel this is happening, it is my responsibility to notify Dr. Jaros and/or Dr. Jay or her staff immediately. I understand that although the infiltrated fluid may cause pain, it is not dangerous to my health and my body will reabsorb the fluid. I realize that during and after my treatment, I may experience minor discomfort at the site of treatment.

I am engaging in this treatment hoping that it will: _____

_____

_____

_____

☐ I understand that Infusion Therapy is considered experimental and there is no guarantee, stated or implied, that this will be a cure-all for my condition. Dr. Jaros and/or Dr. Jay has explained to me that there may be unavoidable side effects, including but not limited to:

- Bruising where the IV was started
- Feeling tired or having diarrhea due to my body's reaction to the detoxifying process
- In an extreme case, if a blood clot forms and passes, it could cause respiratory complications during treatment

☐ I understand that there is no implied or stated guarantee of success or effectiveness of any specific treatment and that I am free to withdraw my consent and discontinue participation in these treatments at any time.

☐ I understand that, except in emergencies, I must give at least 24 hours notice of my intent to cancel or reschedule my appointment.

Patient name (please print): _____

Patient or guardian signature: _____ Date: _____