

Vitality Drip Clinical Policies

PATIENT CONSENT FOR IV INFUSION AND INJECTION THERAPIES WITH VITALITY DRIP.

If you have any questions, please feel free to ask us. Please initial each point acknowledging you understand that:

_____ Services must be paid for at the time of service.

_____ Health insurance typically does not cover services provided at Vitality Drip. If you want to seek insurance reimbursement, we would be happy to provide you itemized invoices that you can submit to your insurance company.

_____ I understand that treatments used at Vitality Drip might not be considered a medical necessity. Treatments rendered are for the purpose of improving your quality of life.

_____ I agree that if I am having any side effects or become sick, that I will follow up with my primary care provider or go to an urgent care or emergency department.

_____ I acknowledge that Vitality Drip is not my primary care provider. I agree that I will continue with routine care through my primary care provider and notify them of treatments prescribed and performed at Vitality Drip.

_____ I understand that there are no refunds for services or products rendered.

_____ I understand that having an appointment with Vitality Drip does not necessarily entitle me to having an IV infusion or injection procedure performed. Every individual is different, and it is at the medical providers discretion to issue treatment.

_____ I understand that I must maintain my follow up appointments and following post procedural care instructions to remain on treatment. It is important that (MEDICAL PROVIDER) manages my treatment and it is at their discretion to provide me ongoing therapies if desired.

_____ I acknowledge that I have been advised of the risks and benefits of treatment. I also acknowledge that I have been advised of possible complications and side effects. I understand the risks, benefits, complications, and side effects of treatment.

_____ I am voluntarily requesting treatment with Vitality Drip in regard to IV infusion therapy and injection therapy as determined by a mutual decision between myself and the medical provider even if it is not considered a medical necessity.

_____ I do not hold any medical practitioner of Vitality Drip responsible for performing age-related preventive care. I agree that I will follow up with my primary care provider to obtain

these screenings and I hold Vitality Drip harmless if an adverse event occurs during my treatment.

I have read, understand, and agree to all of the above statements.

Print Name: _____

Signature: _____ Date _____