

IV THERAPY INFORMED CONSENT AND AUTHORIZATION

Georgia Wellness Solutions

I authorize Georgia Wellness Solutions and its clinical staff to administer intravenous (IV) vitamin, nutrient, and/or hydration therapy as determined appropriate based on my clinical assessment. I understand that IV therapy involves placement of an intravenous catheter to deliver fluids, vitamins, nutrients, and other substances directly into the bloodstream. The purpose, potential benefits, and limitations of IV therapy have been explained to me. I understand that IV therapy is elective, not intended to diagnose, treat, cure, or prevent disease, and that results vary by individual.

I acknowledge that IV therapy carries risks, which may include but are not limited to pain, bruising, swelling, bleeding, irritation at the IV site, phlebitis, infiltration, dizziness, nausea, fainting, allergic or adverse reactions, infection, and, in rare cases, more serious complications. I understand that Georgia Wellness Solutions conducts a clinical screening prior to treatment; however, I acknowledge that it is my responsibility to fully and accurately disclose all relevant medical information, including medical conditions, medications, supplements, pregnancy status, and known allergies. I expressly assume all risk and liability for any complications or adverse outcomes resulting from failure to disclose such information and agree to immediately notify staff of any symptoms, concerns, or changes during or after treatment. Georgia Wellness Solutions is not responsible for complications arising from information not disclosed by the patient.

I understand that alternatives to IV therapy include oral supplementation, dietary modification, or no treatment. I understand that receiving IV therapy services constitutes my consent to treatment. If I wish to withdraw consent, I must verbally notify staff. Failure to communicate withdrawal of consent implies continued consent. Georgia Wellness Solutions is not responsible for adverse outcomes if I do not notify staff of withdrawal of consent.

I acknowledge that no guarantees have been made regarding outcomes. I understand that IV therapy services are typically not covered by insurance and agree to accept full financial responsibility for all charges unless otherwise stated in writing.

By signing below, I acknowledge that I have read and understand this consent and voluntarily agree to IV therapy administered by Georgia Wellness Solutions.

Patient Name: _____

Patient Signature: _____

Date: _____

Provider/Staff Name: _____

Provider/Staff Signature: _____

Date: _____