(937) 642-4400
16705 Square Drive Marysville OH
43040 www.synergymedicalteam.com

IV THERAPY PATIENT CONSULTATION

Name:_____ Gender: M/F Birthdate:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone #:_____ Emergency Contact:_____ #:_____

Email:_____

How did you hear about us?_____

What are your major complaints? (Please 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 or 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 statements best describe why you are here today? (Please check all that apply)

- ☐ I want to have more energy and 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 my surgery or illness
- ☐ I want to slow the aging process
- ☐ I want to feel and look younger
- ☐ I want to have smoother, brighter, and more vibrant skin
- ☐ I want to cleanse my body of toxins
- ☐ I want to recover quickly from a hangover
- ☐ Other:_____

Are you pregnant or breastfeeding? ☐ Yes ☐ No

Date of last chemistry screen or other lab testing:_____

Have you ever been told that you have an electrolyte imbalance or other abnormal labs? ☐ Yes ☐ No

If yes please check appropriate box below (Please check all that apply)

- ☐ Hypermagnesemia (High Magnesium Levels)
- ☐ Hypercalcemia (High Calcium Levels)
- ☐ Hypokalemia (Low Potassium Levels)
- ☐ Hemochromatosis (High Iron Levels)
- ☐ Other:_____

Are you a diabetic? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If Yes, how much do you smoke?_____

How many alcoholic drinks do you consume in a week?_____

Do you exercise? ☐ Yes ☐ No How Many Days a Week?_____

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Do you use any recreational drugs? ☐ Yes ☐ No If Yes, which ones and how often?_____

_____

Are you currently taking any medication? ☐ Yes ☐ No If Yes, please list all medications you are taking (prescriptions, over the counter, vitamins and other supplements):_____

_____

Have you ever had a nutrient IV infusion? ☐ Yes ☐ No When and Where? _____

Do you have any medication or food allergies? ☐ Yes ☐ No If Yes, please list:_____

_____

Do you have any of the following medical conditions? (Please check all that apply)

- ☐ Blood Pressure Problems (High or Low)
- ☐ Heart Problems
- ☐ Stroke or Mini Stroke
- ☐ Kidney Problems
- ☐ Kidney Stones
- ☐ Asthma
- ☐ Optic Nerve Atrophy or Leber's Disease
- ☐ G6PD Deficiency
- ☐ Sarcoidosis
- ☐ Parathyroid Problems (High Levels)
- ☐ Liver Disease
- ☐ Diabetes
- ☐ Congestive Heart Failure
- ☐ Blood clots of any kind
- ☐ HIV/ AIDS
- ☐ Coronary Artery Disease
- ☐ None
- ☐ Fever
- ☐ Blood in stool
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Vomiting
- ☐ Diarrhea
- ☐ No symptoms

List any other medical conditions you have (not mentioned above):

_____

_____

List of all surgical procedures you have had, please include approximate dates:

_____

_____

Is there anything else you'd like the Service Provider to know?

_____

_____

I understand this is an elective procedure and I hereby voluntarily consent to the Intravenous (IV) Therapy Treatment which includes IV delivery of fluids containing vitamins and other natural products ("Services") provided to me by Synergy Medical. The procedure has been fully explained to me. I also understand that any treatment performed is between me and Synergy Medical and I will direct all procedure questions or concerns to Synergy medical. I have read the above and understand it. My questions have been answered satisfactorily. I declare that all the information I have provided on all pages of this application is true and accurate to the best of my knowledge.

I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history I will notify Synergy Medical immediately.

Patient Name (Print):_____

Patient Signature:_____ Date:_____

As to the Services, I understand Synergy Medical will provide Services to me through its duly licensed and authorized employees. I further acknowledge and understand that Synergy Medical has explained to me in general terms the nature and purpose of the Services, what the Services are expected to accomplish, and the reasonably known risks and alternatives to the Services. I represent that:

Synergy Medical has answered all questions about the services to my satisfaction. I further acknowledge that Synergy Medical has made no warranty, express or implied, or guarantee as to the effectiveness of the services provided to me.

I understand and acknowledge IV therapy or booster shots received at Synergy Medical is intended to boost immunity and provide therapies for health and wellness and is not in any way intended to cure, treat, or replace current treatments for disease and illness.

I have reviewed the Notice of privacy practices (HIPAA), have been provided an opportunity to disccuss my right to privacy, and know that upon request, I will be given a copy.

I hereby acknowledge my understanding and agreement to the following which has been explained to me concerning the services:

1. I may experience discomfort, bruising, and pain at the site of the injection.

2. More than one attempt may be needed to start the IV.

3. I may experience inflammation of the vein used for the injection and/or a warming or burning sensation at the site of the injection. Patient will immediately inform Synergy Medical if this occurs.

4.I may experience a warmth or flushing feeling, dizziness, feeling faint, or decreased blood pressure at the start or during the infusion. Patient will immediately inform Synergy Medical if this occurs.

5. I may experience a moderate (hives, itching) to severe (difficulty breathing or swallowing) during treatment. Patient will immediately inform Synergy Medical if this occurs.

6.I may experience an air embolism, fluid overload, and nerve injuries.

7. At the site of an IV injection, I may experience discomfort, pain, bruising, redness, swelling, numbness and/or tingling.

8.After administration of an IV injection, signs of an allergic reaction can occur, including hives, itching, or difficulty breathing. Patient will immediately inform Synergy Medical if this occurs.

9.Although rare, an IV injection can hit nerves nearby and cause weakness on the affected side, which can also lead to pain while walking or sitting, as well as numbness and tingling. Patient will immediately inform Synergy Medical if this occurs.

Patient Signature

Date

IV THERAPY CONSENT

Please read and initial next to each statement acknowledging you understand and agree to each statement.

_____ I have informed Synergy Medical of any known allergies to medications or other substances and of all current medications and supplements. I have fully informed my Service Provider of my medical history. I am also not under the influence of illegal drugs or alcohol.

_____ Intravenous infusion therapy and any claims made about these infusions have not been evaluated by the US Food and Drug Administration (FDA) and are not intended to diagnose, treat, cure, or prevent any 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 performed until I have had an opportunity to receive such information and to give my informed consent.

_____ I understand that:

- The procedure involves inserting a needle into a vein and injecting the prescribed solution.
- Alternatives to intravenous therapy are oral supplementation and / or dietary and lifestyle changes.
- Risks of intravenous therapy include but not limited to:
    a) Occasionally: Discomfort, bruising and pain at the site of injection.
    b) Rarely: Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury.
    c) Extremely Rare: Severe allergic reaction, anaphylaxis, infection, cardiac arrest and death.
- Benefits of intravenous therapy include:
    a) Injectables are not affected by stomach, or intestinal absorption problems.
    b) Total amount of infusion is available to the tissues.
    c) Nutrients are forced into cells by means of a 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 my Service Provider to anticipate and or explain all risk and possible complications. I rely on my Service Provider 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. My signature on this form affirms that I have given my consent to IV Therapy, including any other procedures which, in the opinion of the providers at Synergy medical, may be indicated.

My signature below confirms that:

I understand the information provided on this form and agree to all statements made above. Intravenous (IV) Therapy has been adequately explained to me by my Service Provider. I have received all the information and explanation I desire concerning the procedure. I authorize and consent to the performance of Intravenous (IV) Therapy. I release my Service Provider, and all the staff from all liabilities for any complications or damages associated with my Intravenous (IV) Therapy.

Patient's Name (Please Print): _____

Patient's Signature:_____ Date:_____

Service Provider's Name (Please Print): _____

Service Provider's Signature: _____Date:_____

Parent /Guardian Signature: _____

FINANCIAL

I understand that Synergy Medical does not accept insurance for this service. Upon request, I will be given a receipt that I may submit to my insurance for possible reimbursement. I also understand that if I cancel within 24 hours or do not show up for an appointment, I will be billed the entire amount of the appointment. I have been given the opportunity to ask questions regarding this statement.

_____ _____ _____

Signature of Responsible Party | Printed Name | Date

Practice Policies

You will be evaluated by a trained and licensed provider. We wish to take this opportunity to welcome you and also to state some basic principles we believe are essential in establishing a good relationship between us. Please read through this information, asking questions as needed.

1. INITIAL INTERVIEW: Your first history and physical is considered an evaluation interview and exam. At the time of this appointment, the following decisions will be made with you:
   a) If IV Therapy is an appropriate treatment option
   b) Frequency of IV Therapy infusion sessions
   c) Goals of therapy (what you hope to gain from this process)

2. APPOINTMENTS: Each appointment varies in length depending on your chief complaint. Typically, 20 min infusion appointments take just under 1 hours, and 40 minute infusions are typically around 2 hours in length. At the end of each appointment, you can make arrangements for your next appointment, or you may also book all your prescribed appointments at once.

3. CANCELLATIONS: If you find that you need to cancel an appointment, please give as much notice as possible so that we can schedule people that are on our waiting list. You will be personally charged for your appointment if not canceled at least 24 hours in advance other than for emergency reasons.

4. PAYMENTS: We require payment in full for each visit before the start of your appointment. If you do not have a charge card, we will accept cash and checks. Please make checks out to "Synergy Medical".

5. CONFIDENTIALITY: All information regarding the specific nature of your treatment is maintained at Synergy Medical and is considered confidential within the office unless specified by you in writing. However, each provider at this office reserves the right to use specialty consultation with other medical providers at the office as deemed necessary. We follow HIPAA and maintain confidentiality.

Please initial boxes.

_____ Yes _____ No I acknowledge that I have read and understand all of the foregoing statements and that my signature below indicates that I agree to abide by all of the above conditions.

_____ Yes _____ No I consent to exchange treatment information between Synergy Medical and my primary care or mental health provider.

Provider's Name _____

Patient Printed Name _____ Date: _____

Patient Signature: _____

Parent/ Guardian Signature: _____