Informed Consent to Receive Intravenous Vitamin C Therapy

I,_____, confirm my request to receive and do hereby give my consent for Intravenous Vitamin C Therapy.

Based upon research and information provided to me, I understand that the Intravenous Vitamin C Therapy administered contains high doses of ascorbic acid which not only have a profound effect on enhancing the immune function, but a very positive role in effectively fighting both acute and chronic viral and bacterial infections. I understand that ascorbic acid has been approved by the Food and Drug Administration (FDA) for use as a food supplement and as an essential vitamin and nutrient of the body. Although not officially approved or disapproved for intravenous use, its use intravenously has been well documented in medical literature since the early 1900's. It has been studied in almost all forms of disease, but its most important contribution is in the attainment and maintenance of good health. It has not been reported to be harmful or dangerous when used in the concentrations or dosages utilized in this center.

Although I understand this therapy is expected to improve my condition, I acknowledge my understanding that this therapy is considered controversial and may be deemed an alternative, adjunctive, or unconventional therapy by a majority of conventional physicians in the allopathic medical community because it has not yet been shown to be

"safe" or "effective". I have been informed that other treatment approaches have been used in treating these conditions, including conventional drug therapy and these alternatives have been explained to me to my satisfaction. I understand that the benefits of this therapy are much greater if I follow a healthy lifestyle, such as non-smoking, weight control, proper exercise, proper diet, and nutritional supplementation.

I understand that this therapy consists of intravenous infusions of Vitamin C into a vein and that these treatments may be repeated over a period of weeks or months to achieve maximal benefits. Although I have been informed that this therapy may need to be repeated from time to time in the future in order to maintain its benefits, I understand that it is my option to stop this treatment protocol at any time without incurring any further expense.

I have been informed of the possible risks and side effects of this therapy, which will try to prevent, including but not limited to, discomfort at the injection site, thrombophlebitis (inflammation of a vein associated with clot formation), fatigue, muscle cramps, transient dizziness, allergic reactions, congestive heart failure, anticoagulation, lowering of blood sugar levels and/or hypoglycemia, liver disease, generalized complaints, and on rare occasions, permanent destruction of the vein. In addition, other risks are extremely rare conditions of hemolysis (destruction) of red blood cells and pulmonary embolism. I understand that this therapy should not be used if I am pregnant, unless I have a severe life threatening disease. Further, I have not been asked to discontinue care with any physician and I have indicated any allergies, including corn allergies on my medical history form. I I have suffered from any previous kidney disease, I agree to execute a medical release so that all previously identified medical records of mine may be obtained from previous treating physicians, and I have disclosed openly any previous kidney disorders.

I understand the nature of this therapy and the risks and dangers have been explained to me to my full satisfaction. While I understand that there have been no warranties, assurances, or guarantees of successful treatment made to me, I desire to undergo this therapy after having considered the information I have independently obtained. I consent to receive this therapy and hereby release Subach Spinal Solutions, PLC from any legal responsibility for harm resulting from its use.

I understand that this therapy is not covered by the Medicare program or other medical insurance and that I am personally responsible for payment to Subach Spinal Solutions, PLC at the time services are rendered to me. I acknowledge that I have had the opportunity to ask questions with respect to my full satisfaction.

I, being the client, parent or legal guardian, do hereby acknowledge by my signature on this Informed Consent, my request to receive Intravenous Vitamin C Therapy.

Name:

Signature: Date

Provider Signature: Date