Juventas
SHARING LIFE

Informed Consent for IV Therapy

This consent is intended to provide information to the patient/guardian of the patient, of the possible risks of IV therapy.

I, _____ understand that participating in intravenous (IV) therapy services with Juventas, carries potential risks and I will notify the physician/nurse at Juventas of any medical conditions, recent medical procedures, prescription medications and recreational drug use (including over the counter medications and herbal treatments/therapy), prior to any services.

Potential risks may include but not limited to:

Injury/pain to IV site

Bleeding/hematoma (swelling, bleeding, bruising of the IV site underneath the skin)

Infection

Scarring

Misplacement of IV lines

Air Embolism

Fluid Overload

Medication Adverse Interactions

Permanent nerve injury

Numbness

Lightheadedness, fainting and/or vomiting

Allergic reactions to antiseptic, tape, gauze (itching at the IV site)

(Initial each line below)

_____I understand that while receiving IV Therapy at Juventas, there is more than one patient area to an IV Therapy room and there may be another patient in the same room, receiving IV Therapy at the same time.

_____I acknowledge that I have been made aware of all risks, complications, benefits and alternatives to IV Therapy and have had the opportunity to ask any questions I may have had.

_____I have informed the healthcare provider of my known allergies, medications (including over the counter drugs, recreational drugs, herbal treatments and alcohol use), medical conditions and previous medical procedures.

_____I am aware that there are no guarantees of the outcome of the results with IV therapy and that results may vary.

Financial Policy:

_____I understand that payment is due in full at the time of service. I also understand that this is not a covered service by insurance. I acknowledge Juventas has no contracts with any insurance company and is not contractually obligated to pre-certify treatment with my insurance company or answer letters of appeal.

By signing, I authorize Juventas Plasma LLC to use and/or disclose certain protected health information (PHI) about me if needed.

This authorization permits Juventas Plasma LLC to use and/or disclose the following individually identifiable health information about me include, but are not limited to:

Date(s) of services, type of services, origin of information, age, gender, vital signs

We may use and disclose your PHI in the following ways:

Treatment options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

Health-related benefits and services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

The following categories describe unique scenarios in which we may use or disclose your identifiable health information.

Lawsuits and similar proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

We may release PHI if asked to do so by a law enforcement official.

I have read the above, and I do agree with these terms and consent to participate in receiving IV Therapy with Juventas Plasma LLC.

_____ _____

Print Patient Name *Date of Birth*

_____ _____

Patient/Guardian Signature *Date*