Dr. Jan C. Jay, DOM PC
Desert Mountain Wellness Center
11110 San Rafael Ave. NE
Albuquerque, NM 87122
(505) 323-8100

Consent for Intravenous (IV) Therapy

I, ________________________________, hereby authorize Dr. Jan Jay and her staff to treat me using intravenous therapy. I have shared with Dr. Jay any known allergies that I may have. I understand that this treatment involves inserting a needle and injecting a standardized formula into my veins or muscles. I realize that there may be some discomfort at the sites of treatment and that it is my responsibility to inform Dr. Jay or her staff of any burning, pain, or negative reactions I may be experiencing. During intravenous treatment, it is possible for the injection fluid to leak out of the vein into the surrounding tissue. If I feel this is happening, it is my responsibility to notify Dr. Jay or her staff immediately. I understand that although the infiltrated fluid may cause pain, it is not dangerous to my health and my body will reabsorb the fluid. I realize that during and after my treatment, I may experience minor discomfort at the site of treatment.

I am partaking in this treatment hoping that it will:

____

____

I understand that Vitamin C Therapies is considered experimental and there is no guarantee, stated or implied, that this will be a cure all to my condition. Dr. Jay has explained to me that there may be unavoidable side effects, including, but not limited to:

1. Bruising where the IV was started
2. Feeling tired or having diarrhea due to my body's reaction to the detoxifying process
3. In an extreme case, if a blood clot forms and passes, it could cause respiratory complications during treatment

Dr. Jay has also explained to me what my responsibilities are regarding diet.

I understand that there is no implied or stated guarantee of success or effectiveness of any specific treatment. I understand that I am free to withdraw my consent and discontinue participation in these treatments at any time.

I understand that, except in emergencies, I must give at least 24 hours notice of my intent to cancel or reschedule my appointment.

______________________________________ ______________
Patient Name (Printed) Date

____
Patient Signature