IV NUTRITION CONSULTATION

RevitaLife Wellness Center

777 South New Ballas Road

Suite 1OOE

St. Louis MO 63141

Date:_____

Name:_____ Date of Birth:_____

Address:_____

City_____State_____Zip Code_____

Home Phone: _____ Work Phone: _____

Cell Phone:_____ Email Address:_____

Referred by: _____

Medications: (please list all prescription medications over the counter)

_____

_____

_____

Allergies: _____

1) Have you had IV nutrition therapy before? ___yes ___no
   a. If so, when was your last treatment? _____
   b. Did you have any reaction? ___yes ___no
      If yes, please specify: _____
2) Do you have any specific health concerns that lead you to your decision to try IV nutrition therapy? _____
3) Did something trigger a change in health (illness, surgery, etc)?
   _____
4) Are you pregnant or breast feeding? ___yes ___no
5) Do you have a history of heart disease? ___yes ___no
6) Do you have a history of kidney disease? ___yes ___no

RevitaLife

Patient Consent to Treatment

By reading and signing this document the undersigned patient (or authorized representative) consent to, agree and authorize RevitaLife to perform treatments, examinations, prescribe medications, medical services and diagnostic procedures as ordered and approved by the physician and discussed with me. I understand that I may have other conditions that will continue to be cared for by my primary care physician. I acknowledge and consent to the following:

I) I am at least 18 years of age and I have provided a full and accurate medical history to RevitaLife. I acknowledge that the medical history t provided to RevitaLife is true and accurate and I am aware that any information I did not provide prior treatment cannot hold RevitaUfe personnel me responsible for loss or liability that my result due to my failure to provide such information.

2) I understand and agree that as a to my treatment with Revitalife I will continue to visit my primary care physician, regardless of the extensive follow ups specific to diagnosis discussed by my RevitaLjfe physician or treating personnel.

3) Revitalife physician. and healthcare professionals cannot guarantee any specific results of any examination, treatment, or medical care. I release RevitaLife, its providers, and healthcare professionals from any and all liability for any accident or injury that is not directly caused by the negligence of or its employees. I further that the overall diagnosis and my involve or injuries. As a result. I understand and agree to hold Revitalife and Revitalife physicians harmless and free of liability if I should encounter and adverse event related the treatment or medications prescribed that could result in my incurring additional medical costs.

   During course of my care and treatment, I understand that various types of examinations, tests, and diagnostic or treatment procedures may be necessary. These procedures may be performed by physicians, nurses, technicians or other healthcare professionals. While routinely performed without incident. there may be material risks associated with these procedures; I will ask my healthcare professional or physician to provide me with additional information. I understand RevitaLife personnel and or physicians may ask me to sign additional informed consent documents relating to specific procedures and treatments.

4) I not to give, sell, or allow anyone other than myself to use any medication provided to me through my treatment with RevitaLife.

5) I understand that RevitaLife has contracts with pharmacies for compound medications.

6) I understand that hormones and the ancillary use of mediations while taking hormones or treatment for a specific diagnosis observed by a Revitalife physician can result in the unknown side effects which may become evident until a future date. AS a result, I agree to take my medications exactly in the manner prescribed to me by my RevitaLife physician and agree to release RevitaLife , or RevitaLife and Revitalife physicians from any liability for any misuse, unintended use, or unauthorized use of the medication prescribed.

7) If the medications prescribed may be Injected and I chose to Inject myself, I agree to hold harmless RevitaLife, RevltaLife personnel and or RevitaLife physicians if the results in injury or harm to myself. I understand that Revitalife and for its affiliates will provide as much information and instructions as possible to assist in minimizing harm to myself.

8) I authorize and agree to allow RevitaLife to utilize by lab results, observations and or outcomes of my treatment in future studies which will not disclose my demographic information.

9) I understand that RevitaUfe physicians may have elected to opt out of medical malpractice insurance due to the unique and unconventional nature of the medical treatment. and I cannot hold them responsible and will not attempt to hold them responsible for the diagnosis and treatment, risks, potential harms or injuries or outcomes that may result from initiation or continuation of therapy indefinitely.

10) I understand that RevitaLife may utilize independent contractors for office,outpatient or inpatient treatment/

procedures. These include but are not limited to, assistants, consulting and referral physicians. Healthcare professions that are independent contractors are not agents or employees of RevitaLife and are responsible for their own actions. I understand that RevitaLife shall not be liable for the acts or omissions of the independent contractors. This consent to treatment also applies to any independent contractor utilized by my RevitaLife physician.

I uunderstand that the RevitaLife professionals involved in my care will rely on my documented medical history, as well as other information provided by me, my immediate family, or others having information about me in determining whether to perform or recommend certain procedures or treatment. Throughout the course of my treatment I agree to provide accurate, updated and thorough information regarding my medical history and any conditions or events, which my impact medical decision making.

By signing this document, I certify that I have read and understand its contents and the information provided by me Is accurate and complete.

_____ _____

Patient Signature Date

Optional: I hereby authorize Revitaüfe to use any of my comments as testimonials for future marketing and advertising that may occur. Initials ____

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