1330 N. Indian Canyon Drive Suite. D
Palm Springs, CA. 92262
Ph: 760-656-0243 Fax: 760-656-0263

1. Name: ____

2. Address: ____

3. Telephone Number: ____

4. Email: ____

5. D.O.B: ____

6. Emergency Contact Name: _______________________________

   Telephone Number: ___________________________________

   Relationship: ____

7. Please explain reason for your visit today. Check all that apply.

   ___Dehydration/ hydrate for activity or event
   ___Energy
   ___Alcohol- related illness
   ___Viral Syndrome
   ___Headache/Migraine
   ___Nausea
   ___Vomiting
   ___Diarrhea with nausea and vomiting
   ___Diarrhea without nausea and vomiting
   ___Flu/Flu like symptoms

8. How did you hear about us?
___Social Media ___Walk by ___Flyer ___Search Engine ___Provider __Friend Other______________________

9. Please list current medication with dosage (Including all prescription, over the counter, herbs, vitamins and supplements):

10. Allergies: ____

    Type of Reaction: ____

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11. Have you been hospitalized or under the care of a Physician in the past month? Yes/ No

    Hospital Name ______________________________

12. Medical History:

    Congestive Heart Failure: ____Yes ____No

    Liver Disease: ____Yes _____No

    Kidney Disease or Renal Insufficiency: ____Yes _____No

    Gastrointestinal Bleeding: ___Yes ___No

13. Do you currently take blood thinners? ___Yes ___No

14. Do you currently take or use any type of steroids? ___Yes ___No

15. Are you currently pregnant? ____Yes ___No Date of last menstruation:_________________

INFORMED CONSENT FOR HYDRATION THERAPY SERVICES AND ARBITRATION AGREEMENT
PLEASE INITIAL BELOW:

If you answered ("Yes") to any of the above questions 11-15, it may be advised by the Medical Director that you not receive IV Fluids, and you may be denied services. ______

I understand that participating in the intravenous (IV) hydration and vitamin administration services provided by **The Infusion Center** carries risks. ______

I have truthfully answered all questions regarding my medical history and have informed the staff about any and all prescription medications and/or over the counter drugs I take, as well as any street or recreational drugs. I understand that failing to inform the staff about my medical issues and/or drug use can lead to serious complications. ______

I acknowledge that I am responsible for any medical care I may have that is directly or indirectly related to the services provided by **The Infusion Center**. If I seek medical treatment for any side effect or reaction, it will be at my own expense. ______

I acknowledge and agree that the sole risk of injury or harm resulting in any manner from my voluntary participation in **The Infusion Center**'s services rests entirely with me to the extent that I fail to disclose my health condition(s), medications, or drug use in advance of the services provided. ______

I expressly represent and warrant to **The Infusion Center** that I have never been diagnosed with or treated for any illnesses or conditions that may result in increased risk when participating in the services provided by **The Infusion Center**. I understand that **The Infusion Center** bears no responsibility for and will not screen for, diagnose, monitor, or provide any care for such conditions. ______

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I acknowledge that **The Infusion Center** relies upon information provided by me in assessing my ability to participate in the services provided. ______

IV HYDRATION RISKS INCLUDE THE FOLLOWING:

Injury
Bleeding
Infection
Inflammation/Swelling
Extravasation
Extravasation of fluid
Air Embolism
Damage to surrounding structures (temporary or permanent) due to placement of IV

Fluid overload
Bruising or scarring from insertion of IV
Adverse interactions with medications
Misplacement of IV lines in the body
Nerve injury
Lightheadedness or fainting

I acknowledge that I have been given the opportunity to discuss the nature and purpose of the treatment and the risks, complications, and consequences associated with the procedures. I am aware that it is impossible to foresee or predict all possible risks, complications, and consequences, and I do not expect that the staff to anticipate or explain all associated risks. ______

I waive any and all claims related to the services provided and agree to hold **The Infusion Center** harmless regarding any complications or consequences I experience during or following the service. ______

My signature below confirms that:

I am 18 years or older, of sound mind, and I authorize and consent to the use of hydration therapy.

The procedure set forth above has been adequately explained to me by my attending medical professional.

I have received all of the information that I desire regarding hydration therapy.

This document services as an informed consent for hydration therapy

______________________________________ ______________________________________
Print Signature

____

Date