ReNew Medical Center

Integrative & Regenerative Medicine

INTRAVENOUS (IV) INFUSION THERAPY INTAKE FORM

Patient Information: Date: _____

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Sex: M / F Height: _____ Weight: _____

Occupation: _____ Email address: _____

In case of emergency, contact: Name: _____ Phone: _____

How did you hear about us? ☐ Website ☐ Facebook ☐ Google ☐ Friend: _____

What are your main complaints? (Please check all that apply)

☐ Fatigue or low energy
☐ Stress
☐ Poor diet due to busy lifestyle
☐ Brain fog or trouble concentrating
☐ Low mood or depression
☐ Headaches or migraines
☐ Weight gain or difficulty losing weight
☐ Slow metabolism
☐ Asthma and Allergies
☐ Recent surgical procedure
☐ Recent illness
☐ Cold or flu symptoms
☐ Facial wrinkles or fine lines
☐ Dull or dry skin
☐ Malabsorption issues
☐ Other _____

Which statements best describe why you are here today? (Please check all that apply)

☐ I want to have more energy and feel better overall
☐ I want to do everything I can to nourish my body
☐ I want to do everything I can to enhance my weight loss efforts
☐ I want to prevent getting sick
☐ I want to recover quickly from my surgery or illness
☐ I want to slow the aging process
☐ I want to feel and look younger
☐ I want to have smoother, brighter and more vibrant skin
☐ I want to cleanse my body of toxins
☐ I want to recover quickly from a hangover
☐ Other _____

MEDICAL HISTORY

Are you pregnant or breastfeeding? ☐ Yes ☐ No Date of last chemistry screen/other lab testing _____

Have you ever been told that you have an electrolyte imbalance or other abnormal labs? (Please check all that apply)

- ☐ Hypermagnesemia (High magnesium levels)
- ☐ Hypercalcemia (High calcium levels)
- ☐ Hypokalemia (Low potassium levels)
- ☐ Hemochromatosis (High iron levels)
- ☐ Other _____

Are you a diabetic? ☐ Yes ☐ No Have you been told you are 'prediabetic'? ☐ Yes ☐ No

Are you a smoker? ☐ Yes ☐ No If Yes, how much do you smoke?_____

How many alcoholic drinks do you consume in a week?_____

Do you use any recreational drugs? ☐ Yes ☐ No If Yes, which ones & how often? _____

Please list everything you are currently taking:

Prescription Medications – Strength – Frequency – Condition being treated

_____

_____

Over the Counter Drugs – Strength – Frequency – Condition being treated

_____

_____

Vitamins and Other Supplements – Strength – Frequency – Condition being treated

_____

_____

Do you take Digoxin (Lanoxin) for a heart problem? ☐ Yes ☐ No

Do you take any diuretics or water pills? ☐ Yes ☐ No If Yes, please list: _____

Do you take any steroids, i.e. Prednisone? ☐ Yes ☐ No If Yes, please list: _____

Do you have any medication or food allergies? ☐ Yes ☐ No If Yes, please list: _____

Do you have any of the following conditions? (Please check all that apply)

- ☐ Blood pressure problems (High or low)
- ☐ Heart Problems (or ventricular arrhythmias)
- ☐ Stroke or "mini-stroke"
- ☐ Kidney Problems
- ☐ Kidney Stones
- ☐ Asthma
- ☐ Optic Nerve Atrophy or Leber's Disease
- ☐ Sickle Cell Anemia
- ☐ G6PD Deficiency
- ☐ Sarcoidosis
- ☐ Thyroid/Parathyroid problems (High levels)
- ☐ Pre/Post Menopause
- ☐ Hormonal Inbalances
- ☐ Liver Disease
- ☐ HIV – CD4
- ☐ Hepatitis B
- ☐ High Cholesterol or Lipids
- ☐ Cancer
- ☐ Ulcers
- ☐ Depression
- ☐ Osteoporosis
- ☐ Lung Disease (Asthma, COPD)
- ☐ Arthritis or Joint Problems
- ☐ Headaches/Migraines

Do you take any bonchodialators? ☐ Yes ☐ No

List any other medical conditions you have (not mentioned above):_____

_____

List of all surgical procedures you've had with approximate dates: _____

_____

Is there anything else you'd like the providers to know?_____

_____

Name: _____ Date of Birth: _____

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Intravenous (IV) Infusion Therapy Consent Form

This document is intended to serve as informed consent for your Intravenous (IV) Infusion Therapy as ordered by the provider at ReNew Medical Center.

(Initials)_____ I have informed the nurse and/or physician of any known allergies to medications or other substances and of all current medications and supplements. I have fully informed the nurse and/or physician of my medical history.

(Initials)_____ Intravenous infusion therapy and any claims made about these infusions have not been evaluated by the US Food and Drug Administration (FDA) and are not intended to diagnose, treat, cure, or prevent any medical disease. These IV infusions are not a substitute for your physician's medical care.

(Initials)_____ I understand that I have the right to be informed of the procedure, any feasible alternative options, and the risks and benefits. Except in emergencies, procedures are not performed until I have had an opportunity to receive such information and to give my informed consent.

(Initials)_____ I understand that:
1. The procedure involves inserting a needle into a vein and infusing or injecting the prescribed solution.
2. Alternatives and adjuncts to intravenous therapy are oral supplementation, dietary and lifestyle changes.
3. Risks of intravenous therapy include but not limited to:
    a) Occasionally: Discomfort, bruising and pain at the site of injection, fainting with IV insertion/or infusion
    b) Rarely: Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury.
    c) Extremely Rare: Severe allergic reaction, anaphylaxis, infection, cardiac arrest, and death.
4. Benefits of intravenous therapy include:
    a) Injectables are not affected by stomach, or intestinal absorption problems.
    b) Total amount of infusion is available to the tissues.
    c) Nutrients are forced into cells by means of a high concentration gradient.
    d) Higher doses of nutrients can be given than possible by mouth without intestinal irritation.

(Initials)_____ I am aware that other unforeseeable complications could occur. I do not expect the providers to anticipate and or explain all risk and possible complications. I rely on the staff to exercise judgment during the course of treatment with regards to my procedure. I understand the risks and benefits of the procedure and have had the opportunity to have all of my questions answered. I understand I will be charged a minimum of $45 if the IV is unable to be started for any reason.

(Initials)_____ I understand that I have the right to consent to or refuse any proposed treatment at any time prior to its performance. My signature on this form affirms that I have given my consent to IV Infusion Therapy, including any other procedures which, in the opinion of my providers or other associated with this practice, may be indicated.

My signature below confirms that:
1. I understand the information provided on this form and agree to the all statements made above.
2. Intravenous (IV) Infusion Therapy has been adequately explained to me by the providers.
3. I have received all the information and explanation I desire concerning the procedure.
4. I authorize and consent to the performance of Intravenous (IV) Infusion Therapy.
5. I release Dr. Bruce Schmidt, Marybeth Barcome, FNP, ReNew Medical Center, and all the medical staff from all liabilities for any complications or damages associated with my Intravenous (IV) Infusion Therapy.

Patient's Name & Date of Birth (Please Print) _____ DOB_____

Patient's Signature _____ Date_____

Providers Name & Credentials (Please Print) _____

Providers Signature & Credentials _____ Date _____

HIPAA NOTICE OF PRIVACY PRACTICES

ReNew Medical Center, LLC and their medical staff understand that health information about you is very personal and we are mandated by the Health Insurance Portability and Accountability Act (HIPAA) to protecting your health information. We create a record of the care and services you receive from us, and this record helps to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by us, and informs you about the ways in which we may use and disclose information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this Notice of our legal duties & privacy practices with respect to health information about you
- Follow the terms of the Notice that is currently in effect

How we may use and disclose health information about you:

- For Treatment
- For Payment
- For Healthcare operations
- For appointment reminders
- As required by law
- Public Health risks
- Health oversight activities
- Lawsuits and disputes
- Law enforcement
- To avert a serious threat to health and safety
- As required by the Military or Veterans and Workers Compensation
- Coroners, health examiners and funeral directors
- National Security and Intelligence activities
- Protective Services for the President and others
- Security Officials for Inmates
- For any services provided by ReNew Medical Center

Your rights regarding Health Information about you:

- Right to inspect and copy
- Right to Amend
- Right to Accounting of Disclosures
- Right to Request Restrictions
- Right to Request Confidential Communication

Your Medical Records: The original copy of your and/or electronic medical record is the property of ReNew Medical Center. You may request a copy of your records to be transferred by completing a medical records release form. As allowed by AZ state law, there will be a fee for providing you with this service. We require 14 business days from the date of your request to prepare and send your records unless the records are for urgent of life threatening health issues.
Changes to this Notice: We reserve the right to change this Notice. We will post a copy of the current notice in our facility with the current effective date.
Complaints: If you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing. Please contact the administrator at the location where you were treated to file a complaint. For complete, detailed information regarding privacy laws, visit www.cms.gov/hipaa
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Permission to Share your Health Information: We are required to follow certain federal guidelines and laws regarding the confidentiality of your personal health information. One of these prevents us from discussing anything in your medical file with anyone other than yourself or other medical personnel involved in your care. If you would like us to discuss lab results or other personal information with your significant other, family members, or any other individuals, please fill in their name and relationship to you in the section listed below. _____
_____

Acknowledgement of Receipt of the ReNew Medical Center HIPAA NOTICE OF PRIVACY PRACTICES:
We request that you sign this form acknowledging you have received, read, and reviewed the ReNew Medical Center HIPAA Notice of Privacy Practices. If the patient is a minor, the legal guardian is automatically appointed by law to provide/ receive protected information on behalf of the patient. I will notify the staff of ReNew Medical Center of any changes or updates to this record. This acknowledgement will become part of your records.

Printed Name of Patient _____ Date _____
Signature of Patient _____
Signature of Guardian if patient is a Minor _____ Relationship _____

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Discharge Instructions for Intravenous (IV) Infusion Therapy

How to care for yourself after your IV Vitamin Therapy infusion:

- Apply pressure to site for 2 minutes after IV has been removed
- Keep Band-Aid in place for 1 hour
- Warm packs and elevating your arm can be used for any bruising at the site
- Cold packs can be used for pain relief and to decrease any swelling if present at the site
- Any swelling should be significantly reduced in 24 hours
- Post IV infusion symptoms are uncommon. Dehydration is the cause of most symptoms and concerns.
- We encourage you to drink at least 1-2 16oz. bottles of water after your IV infusion if not contra indicated by your health status.
- If enough water is not consumed, you may experience any of the following symptoms: headaches, nausea, joint pain, blurred vision, cramping (GI and/or muscular), mental confusion or disorientation.

Most patients experience significant overall improvements:

- Better energy
- Better mental clarity
- Improved sleep
- Improvement of their complaints
- Overall feelings of well being

Patients commonly report one of two patterns after an IV Vitamin Therapy infusion:

- Patients generally feel better right away. Due to a busy lifestyle, many people are chronically dehydrated and deficient in vitamins and minerals causing them to not feel well. Once the patient is hydrated and the nutrients are replaced, their symptoms improve quickly.

- Patients sometimes feel tired or unwell. These patients are generally in the process of detoxifying. When toxins are pulled out of tissues, they re-enter the blood stream. They remain poisons, but they are now on their way OUT instead of on their way IN which is the main purpose of hydrating. Even when patients do not feel well at this stage, the process is one of healing and cleansing. After this period, an overall improvement in one's sense of well-being is generally reported.

How often will I need IV Vitamin Therapy infusions?

The number and frequency of treatments will vary depending on certain factors.

- Condition(s) being treated
- Current health status of the patient
- Response of the patient to the treatments

A general estimate of the number of treatments needed is discussed during the first visit. As we go along, we will develop a more specific treatment plan. Most patients will require at least 5-10 treatments. Depending on the response, some patients will then go on to maintenance therapy with occasional treatments.

Call ReNew Medical Center or your Primary Care Physician for:

- Any symptoms you are not comfortable with
- If any of the following are progressively worsening after your IV infusion:
  - Significant swelling over the IV site
  - Redness over the vein that is increasing in size
  - Pain in the vein/arm that is not improving over an 8-12 hour period
  - Headache that does not resolve with increased hydration or over-the-counter pain relievers like aspirin, Acetaminophen or Ibuprofen.

If you feel like you are having a life threatening emergency, please call 911.

Intravenous (IV) Infusion Therapy

Before Your IV Appointment:

- ☐ Complete IV Infusion Intake Paperwork & Medical History
- ☐ Bring list of all prescription medications, OTC medications, vitamins/supplements that you take
- ☐ Bring a copy of your most recent bloodwork is helpful
- ☐ Make sure you are well hydrated prior to your visit, if you are not on water restriction (for example heart or kidney failure). We suggest drinking 1-2 16oz. bottles of water. Dehydration can make it difficult to insert an IV.
- ☐ Make sure you eat something prior to your visit. We suggest bringing a high protein snack, such as nuts, seeds, a protein bar, cheese, yogurt or eggs. Low blood sugar can make you feel weak, light-headed or dizzy.

During your first visit for IV Vitamin Therapy infusions:

During the first visit, our Nurse Practitioner will discuss your main concerns and desired outcomes with you. The NP will review your medical and surgical history and any medications you are taking. Based on this assessment, your Intravenous (IV) infusion will be customized to address your individual needs. If you have any complex medical conditions, our providers may request you obtain blood work or further testing and/or your personal physician's approval prior to administering any IV infusions.

What to expect:

The IVs used during your Intravenous (IV) infusion therapy are exactly the same that you would find in a hospital. Instead of a clinical experience though, our IV infusions are given in a peaceful setting and leave you feeling calm, relaxed, and refreshed.

Depending on your IV cocktail, the infusion can be finished in as little as 30-45 minutes. Our friendly and attentive staff will keep you calm, cared for, and comfortable during your infusion. Patients find the experience tranquil and healing. Patients leave feeling vibrant, energized, and refreshed.