CONSENT FOR IV HYDRATION& VITAMIN/SUPPLEMENT ADMINISTRATION

I understand that participating in intravenous (IV) hydration, vitamin/supplement administration, pharmaceutical administration, and other programs or services offered by AchyJoint carries risks.

I acknowledge that the sole risk of injury or harm which results in any manner from my choice to participate in such program or service rests entirely with me to the extent that I do not disclose my health conditions, medications or drug use in advance.

I confirm to AchyJoint that I have never been diagnosed with nor treated for any illness or condition which may increase my health risk when I participate in a regimen, program or service available **from AchyJoint, and I do not expect AchyJoint to screen for, diagnose, monitor or otherwise provide treatment or care for such conditions.**

I EXPRESSLY CONFIRM TO MY REVIVE WELLNESS PROVIDERTHAT I AM NOT A USER OF ILLEGAL DRUGS AND/OR CONTROLLED SUBSTANCES AND I AM NOT CURRENTLY UNDERTHE INFLUENCE OR RECOVERING FROM THE USE OF THE SAME AT THE TIME THAT SERVICES ARE PROVIDED TO ME.

Risks:

1) Bleeding, injury, infection, swelling/inflammation, bruising or scarring resulting from IV filtration, extraction and extravasation
2) Misplacement of IV lines in the body
3) Air embolism
4) Fluid overload
5) Medication/adverse interactions
6) Nerve injury
7) Lightheadedness or fainting

IN THE EVENT OF AN EMERGENCY, CALL 911 OR PROCEED TO THE NEAREST EMERGENCY ROOM.

I confirm that I have fully read and understand this form. I acknowledge that no guarantees have been made to me concerning expected results intended from services provided by AchyJoint.

I further understand the nature of these services and agree that participating in them carries certain risks.

I have been given an opportunity to ask questions, which have been answered to my satisfaction. I agree to the risks associated with my participation.

By signing, I authorize AchyJoint to use/disclose the following protected health information (PHI) about me if necessary, to include but not limited to:

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

This information will be used for the following: Research data with regards to growth, sales, and types of services requested by our client population. AchyJoint will not receive payment or other remuneration from a third party in exchange for using or disclosing PHI.

I understand that I can revoke this authorization at any time, except to the extent that AchyJoint has acted in reliance upon this authorization.

I have the right to refuse to sign this authorization, and it is not required to receive treatment from AchyJoint.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

Notice of Privacy Practices: AchyJoint is committed to maintaining the privacy of your individual PHI. In conducting business, we will create a record that is unique to you, and the treatment/services that we provide to you. We are required by law to maintain the confidentiality of your PHI. We are also required by law to provide this notice of our legal obligation and our privacy practices with respect to your PHI. Federal and State law requires us to follow the terms of the Notice of Privacy Practices that we have in effect at the time of service.

Here are the ways in which we may use/disclose your PHI:

1) Healthcare operations: We may use/disclose your PHI to operate our business. An example is that we may use your PHI to evaluate quality of care, or to conduct business planning activities to further our business.
2) Treatment options: We may use/disclose your PHI to inform you of potential treatment options or alternatives.
3) Health-related benefits/services: We may use/disclose your PHI to inform you of additional health-related services that may be of interest.
4) Special circumstances: We may use/disclose your PHI in the case that we are required by law to answer a court or administrative order, or if you become involved in a lawsuit or similar proceeding. We also may use/disclose your PHI in response to a discovery request, a subpoena, or other lawful request, but only after we have attempted to inform you of the request or obtained an order to protect the information being requested. We may also use/disclose your PHI in the event we are asked to do so by a law enforcement official.

I have read the above, agree with the AchyJoint terms, and consent to participate in your program.

I, or my legal representative, certify that I have read this document in entirety, that it has been fully explained to me and that I understand its contents, and hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy if requested.

_____ _____

Name of Patient & Date of Birth

Relationship to Patient if Applicable

Or Parent/Legal Guardian/Authorized Representative

_____ _____

Signature of Patient

Date of Signing

Or Parent/Legal Guardian/Authorized Representative