INFORMED CONSENT, CLIENT REPRESENTATIONS/WARRANTIES & DISCLAIMER AGREEMENT

PARTICIPANT RISK:

I understand that participating in intravenous (IV) hydration, vitamin/supplement administration, pharmaceutical administration, programs and services made available by Precision Vascular Access (PVA) carries risks.

I ACKNOWLEDGE AND AGREE THAT THE SOLE RISK OF INJURY OR HARM RESULTING IN ANY MANNER FROM MY CHOOSING TO PARTICIPATE IN SUCH REGIMEN, PROGRAMS AND SERVICES RESTS ENTIRELY WITH ME TO THE EXTENT THAT I DO NOT DISCLOSE MY HEALTH CONDITIONS, MEDICATIONS OR DRUG USE IN ADVANCE.

I expressly represent and warrant to PVA that I have never been diagnosed with nor treated for any diseases, illnesses or conditions which may result in increased risk when I participate in regimens, programs or services made available by PVA, and I am not choosing to participate with any expectation that PVA will screen for, diagnose, monitor or otherwise provide any care or treatment for such conditions.

I acknowledge and understand that PVA is relying upon the foregoing representations and warranties from me upon PVA's acceptance of me for participation in its IV hydration, programs and services.

RISKS INCLUDE THE FOLLOWING:

- INJURY, BLEEDING, INFECTION, INFLAMMATION/SWELLING, BRUISING OR SCARRING RESULTING FROM IV INFILTRATION, EXTRACTION AND EXTRAVASATION
- MISPLACEMENT OF IV LINES IN THE BODY
- AIR EMBOLISM
- FLUID OVERLOAD
- MEDICATION ADVERSE INTERACTIONS
- NERVE INJURIES
- LIGHTHEADEDNESS OR FAINTING

*****WARNING!*****

YOU EXPRESSLY REPRESENT AND WARRANT TO PVA THAT YOU ARE NOT A USER OF ILLEGAL DRUGS AND/OR CONTROLLED SUBSTANCES AND ARE NOT UNDER THE INFLUENCE OF SAME OR RECOVERING FROM USE OF SAME AT THE TIME OF THE PROVISION OF SERVICES TO YOU. IN THE EVENT OF AN EMERGENCY, CALL 911 OR PROCEED TO THE NEAREST EMERGENCY ROOM.

ACKNOWLEDGMENT: I confirm that I have read this form and fully understand its contents. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the sessions and programs offered by PVA. I understand the nature of the sessions and programs and that participating in them carries risks. I have been given an opportunity to ask questions, and all of my questions have been answered fully and to my satisfaction. I agree to my assumption of all risks associated with my participation.

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize PVA to use and/or disclose certain protected health information (PHI) about me if needed.

This authorization permits PVA to use and/or disclose the following individually identifiable health information about me include, but are not limited to:

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

The information will be used or disclosed for the following purpose:

- Obtaining research data to reflect our growth, sales, and types of services requested by our client population.

The purpose is provided so that I can make an informed decision whether to allow release of the information. This authorization will expire one (1) year from date of service.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from PVA. In fact, I have the right to refuse to sign this authorization. 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. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.

Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *protected* health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We may use and disclose your PHI in the following ways:

Health care operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.

Treatment options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

Health-related benefits and services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

Special circumstances:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information

Lawsuits and similar proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

Law enforcement. We may release PHI if asked to do so by a law enforcement official.

I have read the above, do agree with these terms and consent to participate in the PVA program.

Participant's Name (Please Print) **Date & Time**

Participant's Signature

Medical Professional Certification. I hereby certify that I have explained the nature, purpose, benefits, risks of, complications from, alternatives to (including no participation by the client and any attendant risks), the proposed regimen, sessions and programs, have offered to answer any questions and have fully answered all such questions. I believe that the client/agent/relative/guardian fully understands what I have explained and answered.

Specialist's Name (Please Print) **Date & Time**

Specialist's Signature

Participants Signature **Date & Time**

Print Name

Please answer the following questions regarding your health history:

Yes	No	***Do you have or have you ever been treated for any of the following?***
		Heart failure
		Kidney disease
		Liver disease
		Cancer or chemotherapy
		Pregnant or breastfeeding

If you answered "YES" to any of the above, please contact your primary care provider and obtain a doctor's note indicating their permission for you to proceed with hydration therapy.

Please contact *Precision Vascular Access* to alert the nursing staff of your medical condition as soon as possible.

_____ _____

Participant's Name (Please Print) **Date & Time**

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Participant's Signature