IREVIVE HEALTH & WELLNESS, LLC

PATIENT REGISTRATION AND INFORMATION CONSENT FORM

Name:		**Date:**
Address:		**Sex :** MALE / FEMALE (circle one)
City / State:	**ZIP:**	**Date of Birth:**
E-MAIL:		**Age:**
Primary Phone:		**Height:**
Best Phone Number to Reach You For Follow/Up Call?		
How Did You Hear About Our Clinic?		
Name / Phone of Emergency Contact:		
Name / Phone of Primary Doctor:		

Do you have a Membership? □ No □Yes

IV TREATMENTS (PLEASE SELECT ONE)

*** - *Most Popular Treatment*
S - *Current Special ($20 Off)*

□	**Myers Cocktail*** **	$129	1L IV Fluid w/ Essential Multivitamins
□	**Glutathione Treatment**	$129	½ L IV Fluid w/ 2x Normal Dose Antioxidant
□	**Myers PLUS (+)**	$169	Myers Cocktail + IV Glutathione
□	**Migraine Relief**	$129	1L IV Fluid w/ Toradol & Magnesium
□	**Migraine Relief PLUS (+)**	$179	1L IV Fluid w/ Toradol, Magnesium, & Caffeine
□	**Basic**	$49	½ L IV Electrolyte Fluid
□	**Basic PLUS (+)**	$89	1L IV Electrolyte Fluid
□	**IMMUNITY Boost IV** S	$189	1L IV Fluid, High-Dose Vitamin C, Zinc
□	**HANGOVER Recovery** S	$189	Myers Cocktail, B-Complex, Toradol, Zofran

IV MEDICATIONS *ADD-ONS*

□	**IV Toradol**	$20	Non-Narcotic IV Pain Medication
□	**IV Zofran**	$20	IV Anti-Nausea Medication

IV VITAMINS *ADD-ONS*

□	**IV or IM B12**	$15	Natural Energy Boosting Methylcobalamin
□	**IV B-Complex**	$20	Increasing Energy Levels and Brain Function
□	**IV Vitamin C**	$40	Immune System Repair
□	**IV Magnesium**	$20	Anti-Inflammatory and Pain Relief
□	**IV Zinc**	$20	Immunity Booster – aids in nutrient absorption

OTHER IV TREATMENT *ADD-ONS*

□	**IV Amino Acid Blend**	$20	Improving Muscle Growth and Endurance
□	**IV Glutathione**	$40	IV Antioxidant / Anti-Aging
□	**IM Liver Detox Injection**	$35	Lipotropic Injection – Detoxifying Shot
□	**Extra 500mL IV Fluid**	$49	Extra ½ L IV Electrolyte Fluid
□	**Extra 1L IV Fluid**	$60	Extra 1L IV Electrolyte Fluid

CURRENT SYMPTOMS

Please check all that apply	
□	Dry/Sticky Mouth
□	Weakness
□	Sunken Eyes
□	Nausea
□	Increased Thirst
□	Dizziness
□	Sports Related Fatigue
□	Vomiting
□	Dark Colored Urine
□	Loose Stool
□	Illness Related Fatigue
□	Muscle Cramps
□	Lethargy
□	Headache
□	Constipation
□	Decrease Urine Output
□	Dry Skin
□	Loss of Appetite
□	Concentration Difficulty
□	Pale Skin
Other:	

Not sure which treatment is best for you? Leave the IV selections portion blank and one of our providers can review your symptoms/medical history with you to make a recommendation that may be best based on their expert knowledge.

Please let the providers know of any conditions that may affect today's treatment such as fainting or vomiting from needle sticks.

MEDICAL HISTORY

Condition	No	Yes	Date
Heart Disease (Heart attacks, failure, murmurs)			
High Blood Pressure			
Thyroid Disease			
Strokes or Paralysis			
Anxiety / Depression			
Epilepsy / Seizures			
Liver Disease (cirrhosis, hepatitis, yellow jaundice)			
Anemia or other blood disorder			
Diabetes			
Glaucoma or other eye disorder			
Anorexia / Bulimia			

Are you pregnant? □ No □Yes

Condition	No	Yes	Date
Kidney or Bladder Disease			
Blood Clot Disorder			
Cancer			
High Blood Cholesterol			
Stomach Disorder			
Gall Bladder Disease			
Lung Disease (asthma, emphysema, tuberculosis)			
Skin Disorder (unusual or recently changed moles)			
Rheumatic Fever			
Arthritis			

Have you taken any pain Medication today? □ No □Yes

DRUG AND FOOD ALLERGIES

Drug/Food	Reaction

DAILY MEDICATIONS

Name of Medication	Daily Dosage

____Office use only below this point_____________

Physical Assessment - Charting Notes

Date:			
Blood Pressure:		IV Caffeine:	□ 60mg □ _______mg
Heart Rate:		1mL Methylcobalamin:	□ LA □ RA □ LG □ RG □ IV
IV NS:	□ 500mL □1L □1.5L □2L □ ____mL	IM Lipotropic:	□ LA □ RA □ LG □ RG
IV Toradol:	□ 30mg □ 60mg □ _______mg	IV Gage:	□ 18 □ 20 □ 22 □ 24
IV Zofran:	□ 6mg □ 8mg	Left or Right:	□ L □ R
IV MVI:	□ 5mL □ 10mL	Location:	□ AC □ Forearm □ Hand □ Foot
IV Zinc:	□ 1mg	IV Site w/out Infiltration:	□ No Infiltration □ Infiltration
IV Magnesium:	□ 1,000mg	IV DC'd intact:	□ Yes □ No
IV Glutathione:	□ 500mg □ 1,000mg □ ______mg	Tolerated IV Stick:	□ Yes □ No
Ascorbic Acid:	□ 500mg □ 1g □ _____g	Infused via Gravity over:	min
Amino Acid Blend:	□ 2mL	Provider:	
B- Complex:	□ 2mL	Other:	

NOTES:

PATIENT REGISTRATION AND INFORMATION CONSENT FORM

I, _________________________(patient) authorize IRevive Health and Wellness, LLC to assist me in intravenous therapy.
I understand that IRevive Health and Wellness is treating my symptoms and is not making any medical related diagnosis.
I understand that this procedure may be considered medically unnecessary. It may or may not mitigate, alleviate, or cure the condition for which it is being prescribed.
I understand that a follow up with my PCP is advised after treatment.
I understand it is my responsibility to list any and all health history and medications currently being taken.
I understand that IRevive Health and Wellness, practitioners and medical staff, take every precaution to decrease any risk of health related complications associated with Inter Muscular Injections and/or IV administration, but there is still an extremely low risk of complications including but not limited to: Infection at IM/IV site; Pain, swelling, or burning around IM/IV site; Phlebitis; Bruising or injury from vein puncture; Anaphylaxis or other life threatening reactions.
I understand that not all medications have been evaluated by the food and drug administration. Some medications used are in the conceptual phase and have not passed the extensive FDA testing and regulation approval process.
I understand that with extreme dehydration intravenous access may be more difficult, resulting in the inability to administer IV fluid.
I understand all treatments are provided after consult, IRevive Health & Wellness reserves the right to refuse service, postpone therapy, or refer clients to specialized providers as indicated by specific needs.
I understand that **payment is due in full at the time of service**, IRevive Health & Wellness does not bill insurance companies on your behalf.

Patient Signature___________________________________ Date_______________________

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third party payers for my health care services
- Conduct normal healthcare operations such as quality assessment and improvement activities

I have been informed of my medical provider’s Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my medical provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations and I understand that you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

Patient Name: _______________________________ Date: _________________Signature: ________________________________