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INFORMED CONSENT FOR INTRAVENOUS NUTRIENT THERAPY

I, _____ hereby give consent to Dr. Asma Siddiqui, her associates, employees or staff, to perform intravenous vitamin and mineral therapy for the purpose of treatment or prevention of _____. I understand that intravenous nutrient therapy is not standard, widely approved or accepted for this/ these purpose(s) and the view that it is of benefit in the treatment of such disorders is accepted by a minority of the medical community and is considered "experimental" by most physicians. I am advised that my treating physician believes that other treatment approaches have been used in these conditions, including but not limited to prescription medications, over-the-counter drugs and nutritional supplements and these alternatives have been explained to my full satisfaction.

I understand that the benefits of intravenous nutrient therapy are much greater if I follow a healthy lifestyle (non-smoking, weight control, proper exercise, proper diet and nutritional supplementation). I understand that an initial series of treatments may extend over a number of weeks or months. I understand that it is my option to stop at any time with this treatment protocol without incurring any further expense after I have directed that such treatment be stopped. As with any other medical procedure, a small percentage of patients do not respond to this therapy.

I have been informed of possible risks and side effects including but not limited to discomfort at the injection site, thrombophlebitis, fatigue, allergic reaction, congestive heart failure, lowering of blood sugar levels, fever, chills and generalized complaints. I understand that this therapy should not be used if I am pregnant unless I have severe life threatening disease. I understand the nature of the proposed procedure and the risks and dangers have been explained to me to my full satisfaction.

While I understand that there have been no warranties or guarantees of successful treatment made to me, I desire to undergo this treatment after having considered the information contained in this document, the information provided to me through my conversations with my treating physician and through materials that may be provided to me by the office to educate me about the treatment. I acknowledge that I have had the opportunity to ask any questions of my physician with respect to my proposed therapy and the procedures to be utilized and all my questions have been answered to my full satisfaction. My signature on this agreement will constitute a full and final release of any legal responsibility resulting from the administration of intravenous nutrient therapy in my case and/or any other medical treatments that may be necessary as a result thereof.

*Are you taking diuretics and/or Digoxin? _____

_____ _____
PATIENT'S NAME DATE

_____ _____
PATIENT'S SIGNATURE DOCTOR'S SIGNATURE