TRIFECTA
WELLNESS

IV and Injection Therapy Consent Form

(Updated January 2023)

I understand that IV/IM therapy should not be used in patients with severe allergies, a history of anaphylaxis, or history or presence of multiple severe allergies or hypersensitivity to any of the ingredients/medications in the vitamin mix, including glutathione. I have disclosed to my healthcare team any history of severe allergies or anaphylaxis that I have had and understand that failure to do so could result in serious bodily injury or
death. [RequiredSignature]

I understand and accept that IV/IM therapy carries with it both risks and benefits and I acknowledge that it is not possible for the healthcare team at Trifecta Medical Group to screen me for each and every condition which could potentially interact with the IV/IM therapy in a negative way and hereby agree to hold Trifecta Medical Group and its employees harmless from any and all injuries or complications I sustain while undergoing IV/IM therapy. [RequiredSignature]

I have been advised of the healthcare team that alternatives to IV/IM therapy include but are not limited to diet, exercise, oral pain medications and consuming sports drinks/water as well as doing nothing at all. [RequiredSignature]

Risks of intravenous therapy include but not limited to:

a. Occasionally to commonly:
    i. Discomfort, bruising and pain at the site of injection.
b. Rarely:
    i. Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury.
c. Extremely Rarely:
    i. Severe allergic reaction, anaphylaxis, infection, cardiac arrest and death.

I am aware that other unforeseeable complications could occur. I do not expect the provider(s) to anticipate and or explain all risk and possible complications. I rely on the provider(s) 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 hereby release Trifecta Medical Group and its employees and contractors from any liability associated with complications that may occur. [RequiredSignature]

MANDATORY MEDIATION
If a dispute between the parties arises out of or relates to this agreement, the breach thereof, or any performance or obligation due hereunder, and if the dispute cannot be settled through direct negotiation, the parties agree first to try in good faith to settle the dispute by mediation

administered by the American Arbitration Association under its Commercial Mediation Rules before resorting to arbitration, litigation, or some other dispute resolution procedure.

WAIVER OF JURY TRIAL
YOU HEREBY KNOWINGLY, VOLUNTARILY, INTENTIONALLY AND IRREVOCABLY WAIVE THE RIGHT TO A TRIAL BY JURY WITH RESPECT TO ANY LITIGATION ARISING OUT OF THIS AGREEMENT, RELATING TO THE PERFORMANCE OF THE ABOVE-DESCRIBED PROCEDURE, OR ANY OTHER DISPUTE OR CONTROVERSY BETWEEN YOU AND TRIFECTA MEDICAL GROUP.

INFORMED CONSENT: Your consent for this procedure is strictly voluntary and elective. By signing this informed consent form, you hereby grant authority to your provider to perform IV/IM therapy and/or to administer any related treatment as may be deemed necessary or advisable in the diagnosis and treatment of your condition. The nature and purpose of this procedure, with possible alternative methods of treatment as well as complications have been fully explained to your satisfaction. No guarantee has been given by anyone as to the results that may be obtained by this treatment.

I have read this informed consent and certify that I understand its contents in full. I hereby give my consent to this procedure and have been asked to sign this form after my discussion with the provider.

I CONSENT TO THE TREATMENT OR PROCEDURE AND THE RISKS ASSOCIATED WITH THE PROCEDURE. I AM SATISFIED WITH THE EXPLANATION I HAVE RECEIVED AND AM ELECTING TO PROCEED WITH IV/IM THERAPY.
[RequiredSignature]   [CurrentDate]