HANGOVER
HEALTHCARE
IV HYDRATION THERAPY

Patient Registration and Information Consent Form

Today's Date:_____

Name: _____

DOB:_____ Cell Phone:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Email:_____

Emergency Contact:_____Phone:_____

How did you hear about our service?_____

IV Treatments: (All combos come in a 1000 ml Normal Saline bag)

☐ **Myer's Cocktail $169** – fights colds, hangovers and increases athletic performance
B Complex (Vit B1, B2, B3, B5, B6) **+** Mineral Blend (Magnesium, Calcium, Zinc, Copper, Selenium)

☐ **NashVegas Special $199** – **This IV does it ALL** - Hydrate & combat fatigue from dehydration and hangovers, decrease recovery time & enhance your performance, boost your immune system and metabolism, burn fat and feel energized!
Ascorbic Acid (Vit C) **+** B Complex (Vit B1, B2, B3, B5, B6) **+** Methyl B12 **+** Amino Acids (L-Glutamine, L-Arginine, L-Orathine, L-Lysine, L-Citrulline, L-Carnitin) **+** Mineral Blend (Magnesium, Calcium, Zinc, Copper, Selenium)

☐ **Rock Star $249** – When you have partied like a Rock or Country Star! You need to recover from a show, athletic event or even a migraine – this is your combination!
Add'l 500ML bag of fluids **+** Toradol (pain relief) **+** Zofran **+** Pepcid (nausea and/or vomiting) **+** Glutathione for rapid recovery

*Build your own combo with **IV Treatment ADD-Ons:***

Choose: 1 $159, **2**-$179, **3**-$189, **4**-$199, **5**-$209, **6**-$229, **7**-$249, **8**-$269, **9**-$289 (everything IV)

Toradol (non-narcotic pain medication)
Zofran (anti-nausea medication)
Pepcid (Relieves stomach pain, heartburn & reduces acid)
Vita B Complex (B1, B2, B3, B5 & B6)
Mineral Blend (Magnesium, Calcium, Zinc, Manganese, Copper, Selenium)
Amino Blend – (L-Glutamine, L-Arginine, L-Ornithine, L-Lysine, L-Citrulline, L-Carnitine)
Ascorbic Acid – Vitamin C
Glutathione – Tripeptide Amino Acids that increase recovery, and build immune response
Extra bag of fluids (500ml or 1000ml) **$59-$79**

B12 **$29**

Current Dehydration Symptoms**:** *(Circle all that apply)*

Dry/Sticky Mouth
Weakness
Sunken Eyes
Increase Thirst
Dizziness
Sports Related Fatigue
Dark Colored Urine
Vomiting
Illness Related Fatigue
Lethargy
Headache
Constipation
Decreased Urine
Output Dry Skin
Loss of Appetite

Medical History: *(Circle all that apply)*

Heart Disease (Heart attacks, Heart failure, murmurs)
High Blood Pressure
High Cholesterol
Thyroid Disorder
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
Kidney or Bladder Disease Blood Clot Disorder
Cancer
Stomach Disorders
Gall Bladder issues
Lung Disease (asthma, COPD, tuberculosis)
Skin Disorder
Rheumatic Fever
Arthritis

Drug and Food Allergies: *with reactions*

_____
_____
_____

Daily Medications: Name of Med, Dosage, Reason for taking

_____
_____
_____

Informed Consent for Intravenous (IV) Therapy

I hereby give my informed consent for the intravenous administration, vitamin therapy, vitals, basic health risk assessments (prior to any service), and/or other related health services (collectively referred to as “IV therapy”) as set forth herein.

I understand that this document is intended to serve as confirmation of informed consent for IV Therapy as ordered by a licensed healthcare provider and facilitated by Hangover Healthcare, LLC.

- I acknowledge that I have completed the medical questionnaire, the Informed Consent, and that all information is/was answered truthfully, honestly, accurately and to the best of my knowledge.
- I have stated all medications prescribed to me and any recreational drugs or over the counter medicines that I have taken in the last 72 hours on the Patient Registration form.
- I acknowledge that if the medical professional believes that I am under the influence or impaired by alcohol and/or illegal drugs, it is the medical professional’s sole discretion to deny me the services requested. • I have read and agree to the Cancellation Policy Below.

Medical history and personal information divulged during my assessment and IV Therapy will be kept strictly confidential unless I consent to sharing my information by way of a signed release. I understand that I have the right to be informed during the procedure about the risks and benefits, except in emergencies. Procedures are not performed until I have had the opportunity to receive such information and have given my informed consent by executing this document.
The IV Therapy procedure involves inserting a needle and placing a catheter into your vein with the purpose of infusing, over a determined period of time, prescribed nutrients (normal saline with possible additive vitamins, minerals and

amino acids). I understand that risks, benefits and alternatives to IV's may include but are not limited to: 1. The risks and potential side effects:

a. Discomfort, bruising and pain at the site of injection
b. Inflammation of the vein used for injection (infiltration), phlebitis, metabolic disturbances and injury.
c. Severe reaction, anaphylaxis, cardiac arrest or death

2. The benefits:
   a. Injectables are not affected by stomach or intestinal disease.
   b. Total amount of infusions enters the bloodstream and is available to the tissues.
   c. Intravenous hydration allows for an increased absorption of vitamins that cannot always be achieved by oral supplementation. IV therapy avoids the vitamin being broken down in the stomach, which can help avoid irritation to the gastrointestinal tract.
3. Alternatives to IV vitamin therapy are oral supplementation and/or dietary and lifestyle changes.

I understand that IV Therapy is not a substitute for medicine, medical treatment, or the diagnosis, treatment, or cause of disease by a medical provider. I understand no guarantees have been made as to the effectiveness of this treatment.

I am aware that other unforeseeable complications could occur. I understand that the Registered Nurse or Advanced Emergency Medical Technician performing the procedure may have to exercise their best judgement during my IV therapy if such complications occur. I understand the risks and benefits of the IV Therapy and was provided the opportunity to have all my questions answered.

I understand I have the right to consent to or refuse any proposed treatment at any time prior to its performance, subject to the cancellation policy below. With that said, I affirm that I have given my consent for IV therapy with any different or further procedures, which in the opinion of my provider(s) or other(s) associated with this practice, may be indicated.

Cancellation Policy:

If your appointment is not canceled within fifteen (15) minutes of ordering services, you will be charged in accordance with the below:

- If you cancel after 15 minutes, but 24 hours prior to your scheduled appointment, you will be charged a $25 service fee. This covers the credit card service fees associated with your deposit refund.
- If you cancel, refuse to consent, and/or refuse the services once the technician has arrived or anytime thereafter, or you are unable to receive or complete the treatment for ANY reason, you will be charged a $50 non-refundable service fee.
- If the technician arrives for your scheduled service and you are not physically present at the location where the services are to take place, you will be charged a $50 service fee.
- If the technician, in their sole discretion, believes that you are impaired by and/or are under the influence of alcohol and/or illegal drugs, and the technician denies you services, you will be charged a $50 service fee.

I agree to hold Hangover Healthcare, LLC harmless for claims or damages in connection with IV Therapy, I understand that this is a release of potential liability. I understand the information provided on this form and agree to the foregoing, I understand that there is no implied or stated guarantee of success or effectiveness of any treatment. The procedures set forth above have been adequately explained to me by the technician. I understand that I am free to withdraw my consent and to discontinue.

Printed Name of Patient _____

Signature of Patient_____

Date_____

Signature of Witness_____

Date_____

Catheter Size:

# of Sticks:

IV Placement:

Fluid amount:

Additives w/ lot & exp:

IV total price:

Amt Paid & pymt type :