Advance Biomedical
Treatment Center

Eileen C. Comia, M.D.
35 Jolley Drive Suite 102
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INFORMED CONSENT FOR INTRAVENOUS NUTRIENT THERAPY

1. I, _____ (DOB: _____), do hereby request and consent to the use of Intravenous (IV) Nutrient Therapy for the treatment of _____. I understand the procedure will involve intravenous push/infusion possibly combined with diet and lifestyle modifications.

2. I understand that Intravenous Nutrient Therapy is not currently medically accepted for treating _____ and may not be FDA-approved. I am aware and understand the currently "standard" medically-indicated treatment for my condition.

3. The procedure has some risks. The short and long-term risks may include temporary worsening of my current symptoms, failure to obtain substantial benefit, bruising/tenderness at IV site, headache, tachycardia (increased heart rate), syncope (fainting), visual difficulties, shortness of breath, joint pains, red eyes, itchy eyes, nasal congestion, numbness, gastrointestinal disturbances, infection, and anaphylaxis. Further side-effects or complications could be: _____. I accept these risks.

4. Moreover, I understand and accept that because this procedure may be considered "medically unnecessary" or "experimental", it may not mitigate, alleviate, or cure condition(s). Its possible benefits may not be apparent immediately. The possible benefits include improvement of my current symptoms, improvement of respiratory function, decreased skin reactions, increased stamina, improved metabolism, improved concentration, and decrease in frequency or severity of headaches.

5. I further understand and agree to adhere to the treatment schedule and attend the follow-up visits set by Advance Biomedical Treatment Center to permit observation and study my progress. I also agree to comply with the recommended lifestyle modifications in order to provide optimum opportunities for the beneficial effects of the therapy.

6. I understand that I may terminate my treatment at any time by informing Advance Biomedical Treatment Center.

7. I assume full liability for any adverse effects that may result from the administration of the proposed treatment. I waive any claim in law or equity for redress of any grievance that I may have concerning or resulting from the procedure, except as that claim pertains to negligent administration of this procedure.

8. I hereby confirm that the nature and purpose of the treatment(s) may be considered medically unnecessary or experimental and not currently indicated treatments. The risks involved and the possibilities of complications have been explained to me. I fully understand that the treatment to be provided may be considered experimental and unproven by scientific testing and peer-reviewed publication.

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By signing below, I acknowledge that I have read, understood, and agree with the aforementioned statements.

Patient Name: _____

Patient Signature: _____ Date: _____

If a minor, ***both parents must sign and date*** *below. If parents are divorced, please provide proof of legal child custody.*

_____ _____
Signature of Father Date

_____ _____
Signature of Mother Date