Wellness and Optimization Infusions

CENTERS FOR ADVANCED MEDICINE

704-895-WELL (9355) | Fax: 877-706-1786
www.DrButtar.com

Date: _____

Name: _____ Date of Birth: _____

Gender: ☐M ☐F

Address: _____

_____

Phone: _____Email Address: _____

Emergency Contact: _____ Phone: _____

Reason for Visit: _____

Current Medical Condition(s), if any: _____

Current Medications or Supplements, if any: _____

_____

Medication or Latex Allergies? ☐Yes ☐No
If Yes, List:

Anything else we should know about your health/medications?

How did you hear about us?

Cancellation and Financial Policy

Cancellation less than 2 hours prior to treatment will result in full charge with no credit toward future treatment.

Payment is due at time services are rendered, NO EXCEPTIONS.

Patient Signature: _____ Date: _____

Informed Consent for Wellness and Optimization Infusions

I, _____, hereby authorize the following procedure: administration of intravenous vitamins, minerals, and other nutrients.

This procedure is recommended for replacement of these essential nutrients, correction of deficiencies, and for other therapeutic effects, such as improving immune function, improving antioxidant status, reducing oxidative stress, improving fatigue, enhancing overall performance, etc.

The principal side effects that may accompany intravenous administration of nutrients include:

-burning and stinging at the site of infusion or if IV infiltrates into surrounding tissue
-muscular spasms, weakness, or fatigue
-allergic reactions
-local thrombophlebitis

This procedure may be considered medically unnecessary. It may or may not mitigate, alleviate, or cure the condition for which it has been prescribed. This therapy has been recommended to you in the belief that it is of potential benefit in these circumstances and its use will quite possibly improve the condition of your overall health. I understand that the Infusions are only designed to treat symptoms associated with mild dehydration. No labs, x-rays, diagnostic tests or other services will be provided. Wellness and Optimization Infusions can be refused at any time.

We DO NOT guarantee any specific result(s) regarding the Infusions received.

By signing below, I acknowledge that I have read the informed consent and agree to the Infusions with its associated risks. I give consent to perform this and all subsequent Infusions and reserve the right to terminate my session at any given time. I release the Medical Provider, technician performing the Infusion service, and the facility from liability associated with this procedure.

Patient Signature: _____ Date: _____