Maryland Mobile Urgent Care
Healthcare Delivered.

NAME _____Date _____
Informed Consent for Intravenous (IV) Therapy and Injectables

This document is intended to serve as confirmation of informed consent for IV therapy/Injectables as ordered by McCoy Medical Group, LLC operating as Maryland Mobile Urgent Care

(Initials) _____I have informed the nurse of any known allergies to drugs or other substances that may be included in the ingredients of my treatments, or of any past reactions to anesthetics.

(Initials) _____I have informed the nurse of all current medications and supplements.

(Initials) _____I have filled out the Pre-Infusion/Injectable Medical Questionnaire

I understand that I have the right to be informed during the procedure, and the risks and benefits. Except in emergencies, procedures are not performed until I have had an opportunity to receive such information and to give my informed consent.

The IV procedure involves inserting a needle into your vein and infusing over a determined period of time, prescribed nutrients (vitamins, minerals, amino acids, fluids).

I understand that risks, benefits and alternatives to IVs may include but are not limited to:

1. The Risks and potential side effects
○ Discomfort, bruising, and pain at the site of injection.
○ Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury.
○ Severe reaction, anaphylaxis, cardiac arrest, or death.

2. The Benefits
○ Total amount of infusion enters the bloodstream and is available to the tissues.
○ Higher doses of nutrients can be given by vein than by mouth without intestinal irritation that can accompany doses given by mouth.

3. Alternatives to intravenous vitamin therapy are oral supplementation and/or dietary and lifestyle changes.

I am aware that other unforeseeable complications could occur during my treatment or in a limited timeframe after my treatment has been completed.

I understand the risks and benefits of the procedure and have had the opportunity to have all of my questions answered prior to starting the procedure.

I understand that I have the right to consent to or refuse any proposed treatment at any time prior to its performance. My signature on this form affirms that I have given my consent to IV therapy and or an injectable, which in the opinion of McCoy Medical Group, LLC or other(s) associated with this clinic, may be indicated. 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 provided to me today have been adequately explained to me by my Registered Nurse. I understand that I am free to withdraw my consent and to discontinue participation in their treatments at any time.

I understand that I will incur the full fee for treatment, regardless of amount used due to wasted materials. My signature below confirms that:

1. I have received all the information and explanation I desire concerning the procedure.

2. I authorize and consent to the performance of the procedure(s)

Optional:

_____ (initial here) I give my consent to allow McCoy Medical Group, LLC operating as Maryland Mobile Urgent Care to post updates or photographs of me on social media.

_____ (initial here) I give my consent to allow McCoy Medical Group, LLC operating as Maryland Mobile Urgent Care to identify/tag me on social media.

My consent confirms that:

1. I understand the information provided on this form and agree to the statements made above.
2. All information (medial history, medications, allergies, etc) given to Maryland Mobile Urgent Care is accurate.
3. IV/IM infusion treatment has been adequately explained by Maryland Mobile Urgent Care
4. I have received all the information and explanation I desire concerning the procedure.
5. I release McCoy Medical Group, LLC operating as Maryland Mobile Urgent Care and the medical staff from all liabilities for any complications or damages associated with my IM/IV infusion treatment.
6. I am over the age of 18, of sound mind, and capable of making decisions to sign consent, and to receive treatment.

Date:_____Patient Name:_____

Patient Signature: _____

If signed by representative, indicate relationship: _____
Patient/Representative Signature: _____