Patient Information:

Name:_____Date:_____

Address:_____

City:_____State:_____Zip Code:_____

Phone:_____(H)_____(C)_____

Date of Birth_____Age:_____Sex: M / F

Occupation:_____ Email address:_____

In case of emergency, please contact:_____ Phone:_____

How did you hear about us?_____

Would you like to be notified by email of our specials? Yes / No

Which statements best describe why you are here today? (Please check all that apply)

___ I want to have more energy and feel better overall

___ I want to improve my mental clarity

___ I want to strengthen my hair and nails

___ I want to prevent and/or recover from illness

___ I want to help managing my chronic health issues

___ I want to slow the aging process

___ I want to have smoother, more vibrant skin

___ I want to sleep better

___ I want to recover quickly from a hangover

___ I want to enhance my weight loss efforts

___ I want to enhance my athletic performance

___I want to improve my mood

___ I need pain relief

Other_____

Medical History:

Do you have a history of kidney stones or kidney problems? Yes / No

Are you pregnant or breastfeeding? Yes / No

Do you take thyroid or seizure medication? Yes / No

Do you have a sulfa allergy: Yes / No (examples Bactrim or flagyl)

Medical History Continued:

Do you have any of the following conditions? (Please check all that apply)

___ Diabetes

___ Blood pressure problems (High or low)

___ Frequent Headaches

___ Kidney problems

___ Heart Failure

___ Swelling in your lower extremities

___ Bleeding disorders

___ Leber's Disease

___ Liver Disease

___ Currently have an infection

List any other medical conditions you have not mentioned above:

_____

_____

_____

Is there anything else you would like the nurse and physician to know?

_____

_____

_____

Please list any allergies:

_____

_____

_____

Please list any medications you take on a daily basis:

_____

_____

_____

Name and DOB_____

Patient Consent and Agreement

IV Lounge, Inc. (referred to herein as "Company," "we," "us," and/or "our") maintains the policies below. By signing this Patient Consent and Agreement, you agree to receive the services described below from Company and its employed, contracted, and affiliated healthcare providers and you authorize Company to coordinate with your other healthcare providers on your behalf in accordance with the terms set forth below.

1. **Services**. You agree that the services that you receive from Company will consist of IV infusion treatments, injections, laser treatments, weight loss programs and related wellness services performed by healthcare providers who are, as applicable and appropriate, licensed in Michigan (collectively, "Services"). You agree to assume complete and full responsibility to take appropriate action with regard to the recommendations provided by Company's providers. You acknowledge that the Company's providers are not all physicians and are not performing a complete physical examination. You agree that no one at the Company is "on-call" and that you are advised to obtain and maintain a primary care physician for your overall healthcare and on-call needs.

_____ (initial) I acknowledge that I have carefully read the information above and that I agree to it.

2. **Payment for Services**. You agree that you are financially responsible for and will pay all incurred charges for all Services provided by Company and its employees, contractors and providers. You agree that payments are due in full at the time Services are rendered. You agree that Company does not participate in any insurance networks and that Services are not believed to be covered by insurance networks or federal or state third-party payors (e.g., Medicare, Medicaid, etc.). You, therefore, agree to make all payments in cash or other forms of accepted payment directly to Company. It is your responsibility to understand your benefits including, without limitation, your copays, coverage and deductibles, and any required referrals should you seek to obtain reimbursement from third-party payors yourself. You understand that if fees are not paid in full, treatment sessions may be postponed or cancelled until payment is received.

Company maintains a standard fee schedule, subject to change from time to time. All Services shall be paid pursuant to the Company's then-current fee schedule in accordance with Company's then-current payment policies. You understand that all returned checks will be subject to a $40 returned check fee. You understand that Company has the right to forward unpaid accounts to a collections agency and you agree to bear and reimburse Company for all costs including, without limitation, filing fees, service fees, and attorney fees associated with Company's collection efforts on your account.

_____ (initial) I acknowledge that I have carefully read the information above and that I agree to it.

3. **Appointments**. In an effort to facilitate Company's goal of maintaining an efficient schedule for all patients, we ask that you arrive on time fore your scheduled appointment. You should contact Company immediately if you expect your appointment to be delayed or if you are unable to keep your appointment in light of unforeseen circumstances. In general, we request that you provide at least 24 hours' advanced notice of any cancellations. In the event of your late arrival or a missed or cancelled appointment without at least 24-hours' notice provided, you agree that your appointment may need to be rescheduled and that you may be required to pay a $50.00 cancellation fee. You agree that if you arrive late for a scheduled appointment, the session will still end at the scheduled time or may be cancelled by Company, in its sole discretion.

_____ (initial) I acknowledge that I have carefully read the information above and that I agree to it.

4. **Email and Text Communications**. Unencrypted emails and text messages are not recognized as secure communication forms and your agreement to communicate via text or unencrypted emails on a non-confidential basis at your risk. You agree not to send any information you consider private to Company by email or text. Company is not responsible for the security of any information transmitted using any phone number or email address you provide. If you consent to receive texts or emails from Company or any of its employees or contractors, you acknowledge that you are aware of the above-mentioned risks of using text and/or email, you accept and agree to such risks and you agree to receive text and/or email communications from Company and its employees and contractors.

_____ (initial) I acknowledge that I have carefully read the information above and that I agree to it and that I consent to receiving communications from Company by unencrypted emails and appointment reminders via text messages.

5. **Emergency Services**. You hereby agree that Company will not be liable for any failure to provide, or delay in providing, services to you in the event that Company and its providers are assisting another patient(s) in an emergency or in the event of other circumstances beyond the reasonable control of Company. **In the event of an emergency, or a situation in which you could reasonably expect an emergency to arise, you agree to call 911 or visit the nearest emergency room and follow the directions of emergency personnel.**

_____ (initial) I acknowledge that I have carefully read the information above and that I agree to it.

6. **Release and Indemnification**. You acknowledge that Company's non-physician providers are not performing physician services, physical examination, medical and test interpretation services, or any healthcare services outside of Services and Company is not liable for civil damages as a result of acts or omissions in performing Services. You hereby expressly, fully and forever agree to release, waive, indemnify, discharge, and hold harmless Company, its owners, managers, shareholders, medical director(s), investors, directors, officers, representatives, affiliates, employees, providers, agents, and contractors (collectively, the "Indemnified Parties") from, and covenant not to sue any Indemnified Parties for, any and all liabilities, complications, claims, losses, judgments, damages, costs, demands or causes of action, including attorney fees, that you or any of your heirs, assigns, executors, personal and legal representatives, guardians, parents, durable powers of attorney, and next of kin may have at any time for any reason resulting from or related, indirectly or directly, in whole or in part, to Services rendered by Company regardless of any sole, concurrent or contributory negligence, acts, omissions or fault of Indemnified Parties. This Section shall survive termination or expiration of this Patient Consent and Agreement.

_____ (initial) I acknowledge that I have carefully read the information above and that I agree to it.

7. **General Terms**. This Patient Consent and Agreement shall be governed by the laws of the State of Michigan without regard to its conflict of laws provisions. All disputes arising out of, or related to, this Patient Consent and Agreement shall be submitted to binding arbitration in Michigan nearest to the city where Company is located, pursuant to the rules of the American Arbitration Association with one (1) arbitrator to be selected by mutual agreement of both parties. If the parties cannot agree on an arbitrator within thirty (30) days of a party's request for arbitration, then the American Arbitration Association shall select an arbitrator from the National Panel of Arbitrators. You hereby waive your right to trial in any court, however, judgment on the award rendered by the arbitrator may be entered in any court of competent jurisdiction in or nearest to the city where Company is located in Michigan. All costs and expenses of arbitration shall be awarded to the prevailing party, except that each party shall pay for its own legal fees and one-half of the fees and costs of the arbitrator.

8. **Consent to IV Infusion and/or Injectable Therapy**. You voluntarily consent, and authorize Company, to perform Services and you agree that you have been informed about the Services and the purpose, procedures, possible benefits and risks to your satisfaction and you accept them and consent to the Services. You understand that the provision of Services is not an exact science, and you acknowledge that no guarantees have been made to you concerning the results or outcome of the Services. You understand and acknowledge that Services may not achieve your desired outcome. This document is intended to serve as informed consent for your procedure at IV Lounge Inc.

(Initials)____ I have informed the nurse and/or physician of any known contraindications including, without limitation, allergies to medications or other substances and of all current medications and supplements. I have fully informed the nurse and/or physician of my medical history.

(Initials)____Intravenous infusion therapy and any claims made about these infusions/injections have not been evaluated by the US Food and Drug Administration (FDA) and are not intended to diagnose, treat, cure, or prevent any medical disease. These treatments are not a substitute for your physician's medical care. By initialing and signing this consent, I acknowledge that I have been informed about the lack of FDA approval associated with intravenous infusion therapy provided by Company and I understand and accept that the risks and wish to receive the infusions/injections from Company.

(Initials)____ I understand that I have the right to be, and have been, informed of the procedure, any feasible alternative options, and the risks and benefits.

(Initials)____ I understand that:

1) The procedure involves inserting a needle into a vein, muscle or subcutaneous tissue and injecting the prescribed solution.

2) Alternatives include oral supplementation and/or dietary and lifestyle changes. Risks and potential complications are associated with alternative forms of treatment. Other options not mentioned here may exist.

3) Risks of intravenous/intramuscular/subcutaneous therapy include but are not limited to:

    a. Occasionally: Discomfort, bruising and pain at the site of injection.

    b. Rarely: Inflammation of the vein used for injection, phlebitis, and injury.

    c. Extremely Rare: Severe allergic reaction, anaphylaxis, infection, cardiac arrest and death.

4) Benefits of intravenous therapy include:

    a. Injectables are not affected by the stomach, or intestinal absorption problems.

    b. Total amount of infusion is available to the tissues.

    c. Nutrients are forced into cells by means of a high concentration gradient.

    d. Higher doses of nutrients can be given than possible by mouth without intestinal irritation.

5) Contraindications of intravenous therapy include: Pregnancy, breast feeding, heart failure, kidney failure unless a medical clearance is provided by your physician.

(Initials)____ I am aware that other unforeseeable complications could occur. I do not expect the nurse and/or physician to anticipate and/or explain all risk and possible complications. I rely on the nurse and/or physician 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.

(Initials)____ I understand that I have the right to consent to or refuse any proposed treatment at any time prior to its performance. My signature affirms that I have given my consent to IV infusion and/or injectable therapy.

(Initials)____I understand that it is my responsibility in the future to inform the staff of any changes in my medical condition, allergies and/or medications that I take.

Your signature below evidences your voluntary agreement to receive Services from Company, and that you are the patient or are authorized to act on behalf of the patient to sign this Patient Consent and Agreement. By signing below, you agree that you have read, understand, and agree to all of the statements contained in this Patient Consent and Agreement. Your signature below further evidences that you have been informed about the Services and the purpose, procedures, possible benefits and risks to your satisfaction and you accept them and consent to the Services. You understand that the provision of Services is not an exact science, and you acknowledge that no guarantees have been made to you concerning the results or outcome of the Services. You agree that you have been given an opportunity to ask questions before you sign and your questions have been answered to your satisfaction, and you have been told that you can ask other questions at any time. You understand that your agreement is effective on the date signed below and that you may revoke your agreement in writing. Your revocation will not be effective for actions already taken by Company or that are in progress and will only be prospectively effective.

Patient Signature: _____ Date:_____

Printed Name of Patient: _____

(If applicable) Patient Parent/Guardian Signature:_____

Patient's Parent/Guardian Printed Name:_____

Witness Signature_____Date: _____