IVX HEALTH

Informed Consent for Treatment

I, _____, **(Patient Name)** hereby give consent to IVXpress, Inc. (IVX Health) to perform intravenous infusion, intramuscular injection, or subcutaneous injection of vitamins, mineral therapy, nutrition therapy or prescription medication as prescribed. I have been informed of and understand the treatment that I will receive and accept to proceed with such treatment. I acknowledge the Informed Consent for Treatment document at the time of check-in and have no questions.

My signature on this agreement will constitute a full and final release of any legal responsibility resulting from the administration of intravenous or injection therapy in my case and/or any other medical treatments that may be necessary as a result thereof to include the additional administration of medications for the management of infusion/injection reactions and possible transfer to an acute care facility (e.g. hospital). My signature further authorizes the initial and all subsequent administrations of infusions at IVX Health.

_____ _____

Signature of Patient or Legal Guardian (required) **Date**

HIPAA Confidentiality Agreement

By signing this document, I acknowledge I have read and understand the policies of HIPAA and OSHA. I acknowledge that my time at IVX Health may put me in direct contact with Protected Health Information, and therefore understand that all I see and hear is confidential. I understand that it is imperative I do not interfere with or disrupt patient care in any way and will leave the area promptly if asked to do so. I am aware that there are risks involved in being present in a patient care setting. These risks include, but are not limited to, exposure to common viral and bacterial infections and airborne and blood borne pathogens. I acknowledge I have read and reviewed the full HIPAA Confidentiality Agreement presented to me at the time of check-in and have no questions.

_____ _____

Signature of Patient or Legal Guardian (required) **Date**

Authorization to Disclose Protected Health Information (PHI)

By signing this document, I acknowledge I have read and understand the full Patient Privacy Practices and Financial Policies presented to me at the time of check-in and have no questions. I grant IVXpress, Inc. (IVX Health) permission to disclose PHI to the designated individuals.

Person(s) or Association(s): _____ Phone: _____

Address: _____ Relationship: _____

City: _____ State: _____ Zip: _____

_____ _____

Signature of Patient or Legal Guardian (required) **Date**