Auth Chiropractic & Vitality

Chelation, Ozone, Infusion & Wellness

3% Peroxide Intravenous Therapy Consent

I ______________________________, am choosing, of my own free will, to receive intravenous 3% peroxide therapy at Auth Vitality: Chelation and Wellness of the Rockies, administered by ______________________________. This alternative therapy, although discounted by conventional medicine, has a 50-year track record of safety.

I affirm that I do not currently present any of the following conditions: allergy to Peroxide, currently pregnant or breastfeeding, severe anemia, thyrotoxicosis, hemophilia, porphyria, active infection, extremely low platelet count, severe kidney disease (eGFR <30), receiving dialysis therapy, have uncontrolled diabetes, uncontrolled hyper or hypotension, or severe liver disease. I affirm that I have shared my complete medical, surgical, allergy, and known family history with my provider prior to receiving this therapy.

I understand that as with any intravenous therapy, risks include bleeding; transient hypoglycemia, headache and/or light-headedness, local swelling, bruising, irritation or infection at the insertion site, a brief resetting of my menstrual cycle, and the risk of mild hemolysis if I have a G6PD deficiency. I understand that I may experience any number of side effects, and that all side effects are not known, but can occur during or after therapy.

I understand that Auth Vitality: Chelation and Wellness of the Rockies and its clinical providers, make no warranties, claims, or guarantees about these alternative therapies with respect to my condition. I am freely partaking in this treatment, and as such my willing participation in this treatment represents a “good faith” effort by the provider. Should harm come to me, I and my representatives will hold harmless Auth Vitality: Chelation and Wellness of the Rockies and its clinical providers.

I acknowledge that it is my right to cease 3% peroxide IV therapy at any time for any reason. I understand that I should follow up with the administering provider within 1-3 days if I should have any symptoms of concern. I am consulting with Auth Vitality: Chelation and Wellness of the Rockies, solely for reasons concerning my own health. I am not consulting to provide information to any enforcement or investigative agency. I understand that this procedure is not covered by insurance carriers and agree to the complete financial responsibility of my services.

With full awareness of the above facts and considerations, I give my consent to Auth Vitality: Chelation and Wellness of the Rockies and its staff, to receiving one or multiple 3% peroxide infusion treatments.

Patient name: ______________________________

Patient signature: ______________________________ Date: ______________

Provider name: ______________________________

Provider signature: ______________________________ Date: ______________