EVND
east valley naturopathic doctors

Name: _____ DOB: _____ Date:_____

PLEASE INITIAL THE FOLLOWING:

_____ **Consent to Injections; PRP and Prolotherapy:** I consent to all injection procedures rendered by the doctor who are now or will in the future treat me while employed by or associated with this practice. I understand there are risks to injections including but not limited to severe pain, bruising, inflammation, injury, numbness, allergic reaction and infection. I do not expect the doctor to anticipate and or explain all risks and possible complications. I rely on the doctor to exercise judgment during the course of treatment with regards to any procedure. I intend this consent to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment.

_____ I understand that injection therapies provided may not be approved by the United States Food and Drug Administration for the treatment of my medical condition.

____ **Consent to Intravenous Therapy:** I consent to all intravenous therapy procedures rendered by the doctor(s) who are now or will in the future treat me while employed by or associated with this practice. I understand that there are risks to intravenous therapy including but not limited to pain, bruising, inflammation, injury, infection, allergic reaction and metabolic disturbances. I do not expect the doctor(s) to anticipate and or explain all risks and possible complications. I rely on the doctor(s) to exercise judgment during the course of treatment with regards to my procedure. I intend this consent to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment.

_____ I understand that injection therapies provided may not be approved by the United States Food and Drug Administration for the treatment of my medical condition.

I have read, understand and agree to all of the above initialed policies.

_____ _____

Patient / Guardian Name (Print) Patient / Guardian Signature Date