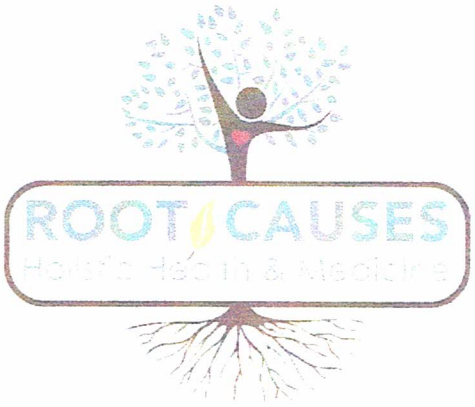

Informed Consent for Intravenous Nutritional Therapy

I,_____ have requested intravenous infusion(s) containing, but not limited to, Magnesium, Calcium, B-12, Pyridoxine, Dexpanthenol, Vitamin B complex, Vitamin C, Multiple Trace Elements, Potassium, and/or other nutrients and/or additives. My physician has informed me that there are other methods available to treat my condition, or to increase my vitamin intake, and or to increase my general wellness. My physician has also informed me that there is a very small possibility that I may experience mild side effects such as: Discomfort at the injection site, thrombophlebitis, nausea, vomiting, headache, dizziness, syncope (fainting) and allergic reactions. Every effort will be made to avoid those side effects.

I have been informed that the services are "non-covered" services and not considered reasonable and necessary under Medicare and other insurance programs. I understand that insurance and Medicare coverage will not pay for non-covered services and that I will be personally responsible for payment to Root Causes Holistic Health & Medicine for all such non-covered services at the time services are rendered to me.

I have read the above and has all questions answered to my satisfaction. I acknowledge by my signature below that I understand what I am signing and herby request and consent to receive intravenous multiple vitamin, mineral treatment(s). No guarantees have been given to me as to what the results may be obtained.

_____ _____ _____

Name **Signature** **Date**

_____

Date of Birth

_____ _____

Witness **Date**