Intake Questionnaire

Professional Concierge Nursing
11321 Iowa Ave, Suite 2, Los Angeles, CA 90025
310-844-3440 www.pcnursingca.com

Date: _____

Name: _____ DOB:_____ Age: _____

Address:

_____

_____

Phone: _____Email: _____

Reason for visit:

_____

Emergency Contact:

_____

Please briefly describe why you are seeking IV infusion or injection therapy? For example: Are you looking to improve your energy, skin/hair/nail quality, recovery times, immune system, or hydration status? Are you seeking treatment for a hangover or looking to feel and look better?

_____

_____

_____

_____

_____

Allergies (Medications, foods, etc.):

_____

_____

_____

Current Medications: (Please include OTC & supplements)

_____

_____

_____

_____

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Please check any conditions that apply to you:

CARDIOVASCULAR AND RESPIRATORY

- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Valve Disorder
- ☐ Abnormal Rhythm
- ☐ Chest Pain
- ☐ Heart Attack
- ☐ Cardiac Surgery or Stents
- ☐ Congestive Heart Failure
- ☐ Peripheral Artery Disease
- ☐ Thrombosis or DVT
- ☐ Aneurysm
- ☐ Asthma
- ☐ COPD
- ☐ Sleep Apnea
- ☐ Shortness of Breath
- ☐ Pulmonary Hypertension
- ☐ Lung Cancer
- ☐ Other Lung Disorder _____
- ☐ Other Cardiac Disorder _____

GASTROINTESTINAL AND URINARY

- ☐ Acid Reflux
- ☐ Liver Disease
- ☐ Bladder Disease
- ☐ Hepatitis A, B, C
- ☐ Kidney Disease
- ☐ Other _____

METABOLIC/ENDOCRINE/AUTOIMMUNE

- ☐ Hyper/Hypo Thyroid
- ☐ Rheumatoid Arthritis
- ☐ Diabetes Type I Type II
- ☐ Hx of DKA
- ☐ Lupus
- ☐ Other _____

NEUROLOGIC

- ☐ Stroke/TIA
- ☐ Multiple Sclerosis
- ☐ Parkinson's
- ☐ Seizures – date of last seizure _____
- ☐ Alzheimer's

HEMATOLOGY

- ☐ Anemia (Iron Deficiency, Pernicious, Aplastic, Hemolytic, Sickle Cell)
- ☐ MTHFR
- ☐ G6PD Deficiency

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MUSCULOSKELETAL

☐Back Pain ☐Degenerative Joint Disease
☐ Carpal Tunnel Syndrome ☐Degenerative Disk Disease
☐ Fibromyalgia ☐Other_____

PSYCHOLOGICAL

☐ Depression
☐ Anxiety or Panic Attacks
☐Suicidal Ideations

CANCER

☐ Location of cancer _____
☐Chemotherapy
☐Radiation

WOMEN (non-menopausal)

Last Menstrual Period _____ Any chance that you are pregnant? _____
Are you currently breastfeeding? _____

PAIN

☐CRPS
☐Fibromyalgia

Do you drunk alcohol or abuse any types of drugs? If so, please explain:

_____
_____
_____

Have you ever had an electrolyte or fluid imbalance in the past? Such as low potassium, high sodium, etc.?

_____
_____
_____
_____

Would you like to tell us anything else that you feel like is important?

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_____

_____

_____

_____

I attest that the information I have provided is true and accurate to the best of my knowledge:

_____

Signature Date

_____

Print name

Privacy Policy

OUR LEGAL RESPONSIBILITIES

We are required by law to give you this notice. It provides you on how we may use and disclose protected health information about you and describes your rights and our obligations regarding the use and disclosure of that information. We shall maintain the privacy of protected health information and provide you with notice of our legal duties and privacy practices with respect to your protected health information.

We have the right to change these policies at any time. If we change our privacy policies, we will notify you of these changes immediately. This current policy is in effect unless stated otherwise. If the policy is changed, it will apply to all your current and past health information.

You may request a copy of our notice any time. You may contact J. Rapha Management, Incorporated dba Professional Concierge Nursing at 11321 Iowa Avenue, Suite 2, Los Angeles, CA 90025, 310-844-3440, regina@jraphamanagement.com at any time to request a copy of this privacy policy.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following examples describe ways that we may use your protected health information for your treatment, payments, healthcare operations etc. but please be advised that not every use or disclosure in a particular category will be listed.

Treatment: We may use and disclose your protected health information to provide you treatment. This includes disclosing your protected health information to other medical providers, trainees, therapists, medical staff, and office staff that are involved in your health care.

For example, your medical provider might need to consult with another provider to coordinate your care. Also, the office staff may need to use and disclose your protected health information to other individuals outside of our office such as the pharmacy when a prescription is called in.

Payment: Your protected health information may also be used to obtain payment from an insurance company or another third part. This may include providing an insurance company your protected health information for a pre-authorization for a medication we prescribed.

Health Care Operations: We may use or disclose your protected health information in order to operate this medical practice. These activities include training students, reviewing cases with employees, utilizing your information to improve the quality of care, and contacting you be telephone, email, or text to remind you of your appointments.

If we have to share your protected health information to third party “business associates” such as a billing service, if so, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may also use and disclose your protected health information for marketing activities. For example, we might send you a thank you card in the mail with a coupon for specialized services or products. We may also send you information about products or services that might be of interest to you. You can contact us at any point to stop receiving this information.

We will not use or disclose your protected health information for any purpose other than those identified in this policy without your specific, written Authorization. You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. You can revoke this authorization at any time but will not affect the protected health information that was shared while the authorization was in effect.

Appointment reminders: We may contact you as a reminder that you have an appointment for your initial visit, follow up visit, or lab work via text, phone or email.

Others Involved in Your Health Care: We may disclose protected health information about you to your family members or friends if we obtain your verbal agreement to do so, or if we give you an opportunity to object to such a disclosure and you do not raise an objection. For example, we may assume that if your spouse or friend is present during your evaluation, that we can disclose protected professional information to this person. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment if there is an urgent or emergent need.

Research: We will not use or disclose your health information for research purposes unless you give us authorization to do so.

Organ Donation: If you are an organ donor, we may release protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation if it is necessary to facilitate this process.

Public Health Risks: We may disclose your protected health information, if necessary, in order to prevent or control disease, report adverse events from medications or products, prevent injury, disability or death. This information may be disclosed to healthcare systems, government agencies, or public health authorities. We may have to disclose your protected health information to the Food and Drug Administration to report adverse events, defects, problems, enable recalls etc. if required by FDA regulation.

Health Oversight Activities: We may disclose protected health information to health oversight agencies for audits, investigations, inspections or licensing purposes. These disclosures might be necessary for state and federal agencies to monitor healthcare systems and compliance with civil law.

Required by Law: We will disclose protected health information about you when required to do so by federal, state and/or local law.

Workman's compensation: We may disclose your protected health information to workman's comp or similar programs.

Lawsuits: We may disclose your protected health information in response to a court action, administrative action or a subpoena.

Law Enforcement: We may release protected health information to a law enforcement official in response to a court order, subpoena, warrant, subject to all applicable legal requirements.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Access to medical records: You have the right to access and receive copies of your protected health information that we use to make decisions about your care. You must submit a written request to obtain your protected health information to the individual listed at the end of this privacy policy. We reserve the right to charge you a fee for the time it takes to obtain and copy the protected health information and provide it to you.

Amendment: If you believe the protected health information, we have about you is incorrect or incomplete, you may ask us to amend the information You will need to submit a written request on why you feel the health information should be amended. We may deny your request to amend if you did not send a written request or give a reason on why it should be amended. If we deny your request, we will provide you a written explanation. We may deny your request if we believe the protected health information is accurate and complete.

Accounting of Disclosures: You have the right to receive a list of instances in which we disclosed your personal health information unless the disclosure was used for treatment, payment, healthcare operations, was pursuant to a valid authorization and as otherwise provided in applicable federal and state laws and regulations. You must submit a written request to obtain this "accounting of disclosures" to the individual listed at the bottom of this policy. After your request has been approved, we will provide you the dates of the disclosure, the name of the individual or entity we disclosed the information to, a description of the information that was disclosed, the reason why it was disclosed, and any additional pertinent information. This information may not be longer than (STATUTE OF LIMITATIONS) years ago prior to the date the accounting is requested. We reserve the right to charge a reasonable fee for this process.

Restriction Requests: You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment, or healthcare operations. We shall accommodate your request except where the disclosure is required by law. We require this be a written request submitted to the individual at the end of this policy.

Confidential Communication: You have the right to request that we communicate with you about healthcare matters in a certain way and at a certain location. We must accommodate your request if it is reasonable and allows us to continue to collect payments and bill you.

Paper copy of this notice: You may request a hard copy of this practice policy if you reviewed and signed it via electronic means. To obtain this copy, contact the individual at the end of this privacy policy.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with our office. You also file a complaint with the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

Name of Contact Person:

Regina Speights, regina@jraphamanagement.com, 310-844-3440
11321 Iowa Avenue, Suite 2, Los Angeles, CA 90025

Please sign and date indicating you have read and understand you're Patient Rights.

Name_____Date_____

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Including Medical and Mental Health Records

Patient's Name: _____ Date of Birth: _____

Previous Name(s): _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone#: _____ Fax#: _____

Federal Regulation, 42 CFR Part 2, requires that a description of the amount, the kind of information that is to be disclosed and the purpose for this disclosure.

This request and authorization applies to: ☐ All records available ☐ All correspondence

Or the specific records indicated here:

☐ Psychiatric Evaluation
☐ Diagnosis
☐ Summary of Treatment
☐ Medications
☐ Psychological Assessment
☐ Other (specify)_____
☐ Psychological Testing
☐ School Evaluation
☐ History
☐ Legal issues/concerns
☐ Performance

and is to be released for the purpose of: ☐ Continuity of care ☐ Other: (specify) _____.

By checking the boxes below, I specifically authorize the voluntary release of the following types of medical records, if such records exist.

☐ Yes ☐ No I authorize the release of my HIV/AIDS records, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

This consent to release is valid for one year, or until otherwise specified, and thereafter is invalid. Specify date, event, or condition on which permission will expire: _____
I understand that at any time between the time of signing and the expiration date listed above I have the right to revoke this consent at any time to the extent that information has already been released based on this authorization.

Patient Signature:_____ Date Signed:_____

Relationship to patient: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

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www.pcnursingca.com 310-844-3440

Professional Concierge Nursing Clinical Policies

PATIENT CONSENT FOR IV INFUSION AND INJECTION THERAPIES WITH J. Rapha Management, Incorporated dba Professional Concierge Nursing

If you have any questions, please feel free to ask us. Please initial each point acknowledging you understand that:

_____ If you are late or miss your appointment, you may be subject to a $50 fee.

_____Services must be paid for at the time of service.

_____Health insurance typically does not cover services provided at Professional Concierge Nursing. If you want to seek insurance reimbursement, we would be happy to provide you itemized invoices that you can submit to your insurance company.

_____Since each insurance company has its own policies regarding the coverage of procedures, I also acknowledge that I am responsible for payment in full for the charges incurred for procedures and treatment regardless of the coverage provided by my insurance carrier.

_____I understand that treatments used at Professional Concierge Nursing might not be considered a medical necessity. Treatments rendered are for the purpose of improving your quality of life.

_____ I agree that if I am having any side effects or become sick, that I will follow up with my primary care provider or go to an urgent care or emergency department.

_____I acknowledge that Professional Concierge Nursing and Regina Speights, DNP, FNP-C are not my primary care provider. I agree that I will continue with routine care through my primary care provider and notify them of treatments prescribed and performed at Professional Concierge Nursing.

_____I understand that there are no refunds for services or products rendered.

_____I understand that having an appointment with Professional Concierge Nursing does not necessarily entitle me to having an IV infusion or injection procedure performed. Every individual is different, and it is at the medical providers discretion to issue treatment.

_____I understand that I must maintain my follow up appointments and following post procedural care instructions to remain on treatment. It is important that Regina Speights, DNP, FNP-C manages my treatment, and it is at their discretion to provide me ongoing therapies if desired.

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_____I acknowledge that I have been advised of the risks and benefits of treatment. I also acknowledge that I have been advised of possible complications and side effects. I understand the risks, benefits, complications, and side effects of treatment.

_____I am voluntarily requesting treatment with Professional Concierge Nursing and Regina Speights, DNP, FNP-C in regard to IV infusion therapy and injection therapy as determined by a mutual decision between myself and the medical provider even if it is not considered a medical necessity.

_____I do not hold any medical practitioner of Professional Concierge Nursing responsible for performing age-related preventive care. I agree that I will follow up with my primary care provider to obtain these screenings and I hold Professional Concierge Nursing and Regina Speights, DNP, FNP-C harmless if an adverse event occurs during my treatment.

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

Print Name:_____

Signature:_____Date_____

Indemnification Clause

I, _____, agree to indemnify, defend, protect, and hold harmless the medical providers employed by Professional Concierge Nursing ; and their respective officers, directors, employees, stockholders, assigns, successors and affiliates (Indemnified Parties) from, against and in respect of all liabilities, losses, claims, damages, judgements, settlement payments, deficiencies, penalties, fines, interest and costs, expenses suffered, sustained, incurred or paid by the indemnified parties, in connection with, results from or arising out of, directly or indirectly, the medical providers employed by Professional Concierge Nursing and Regina Speights, DNP, FNP-C; rendering medical care, services, advice, and/or treatment, my failure to disclose all relevant information regarding my medical and physical condition, acts or omissions, the medical providers employed by Professional Concierge Nursing and Regina Speights, DNP, FNP-C; harm or injury resulting from medical care or pharmaceuticals provided directly or indirectly by the medical providers employed by Professional Concierge Nursing and Regina Speights, DNP, FNP-C. I am aware of the potential side effects associated with IV infusion and injectable therapies provided by Professional Concierge Nursing, and accept all the risks involved with IV infusion and injectable therapies, and will not seek indemnification or damages from the indemnified parties.

Printed Name:_____

Signature:_____Date:_____

Witness:_____Date:_____

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Pre and Post Visit Instructions

To have a safe and effective IV therapy session, it is important that you adhere to the following pre- and post-visit instructions.

Before your appointment:

- Plan to be at the clinic at least 15 minutes before your infusion to fill out necessary paperwork if you are a first-time patient.
    - If you are a repeat patient, then arrive 5 minutes before infusion.
- You can take your regular medications as normal on the day of treatment. If you are taking any of the following medications, you must hold them the day of your treatment:

After your IV infusion:

- Continue to wear dressing applied to the IV infusion site for 1 hour to prevent break through bleeding.
- You can apply cold packs or take naproxen (Aleve) for any post injection/infusion pain.
- A light meal and 16 ounces of water are recommended after the infusion
- Monitor your IV site for redness, pain, warmth, or swelling. This could be a sign of infection or an adverse reaction. If this occurs, please call PROFESSIONAL CONCIERGE NURSING at 310-844-3440.
- Continue routine follow up with your mental health and/or primary care provider for continued treatment and evaluation.
- If any mild side effects occur such as hives, nausea, fever, cramping, headaches, or any additional non-life-threatening symptoms, please call PROFESSIONAL CONCIERGE NURSING at 310-844-3440 immediately. If it is after hours, then please report to your closest urgent care or emergency department.
- If any type of serious adverse events occurs such as diffuse hives, shortness of breath, trouble swallowing, chest pain, severe headache, changes in consciousness, increase pain/swelling in the arm that the infusion was given in, or anything else that is concerning, call 911 or report to the emergency department immediately.
- You can expect to feel improvements in your symptoms within 15-90 minutes of your infusion. These effects can last up to 1 to 1 and a half weeks.

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- Patients can present for repeat infusions every 2 weeks unless determined otherwise by your treating provider.

Additional instructions:

_____

_____

_____

If you have any additional questions or concerns, please feel free to reach out to PROFESSIONAL CONCIERGE NURSING, 11321 Iowa Avenue, Suite 2, Los Angeles, CA 90025, 310-844-3440, regina@jraphamanagement.com

Your next appointment date and time:

_____

I acknowledge that I understand the instructions that need to be followed prior to and after my treatment. I certify that I will follow these instructions and notify PROFESSIONAL CONCIERGE NURSING and REGINA SPEIGHTS, DNP, FNP-C of any changes in my condition or drug/supplement use.

Printed patient name:

_____

Patient signature: _____

Date:_____

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IV Infusion and Injection Consent Form

This form outlines that you understand that a peripheral intravenous catheter will be inserted into a vein in your body, and you will have fluids, vitamins, minerals, nutrient, and/or medications infused directly into your body. This is considered "IV Infusion Therapy." If you are having injection therapy, then you understand that a vitamin, mineral, nutritional compound, and/or medication will be injected directly into the subcutaneous fat or muscle of your body. This is considered "Injection Therapy."

Please initial each point bellowing acknowledging that:

_____ I understand that IV infusion and injection therapy at Professional Concierge Nursing is not intended to diagnose or treat a specific medical condition.

_____ I understand that IV infusion and injection therapy will not prevent, treat, or cure and medical condition or disease. Furthermore, I understand that I am here seeking IV infusion and/or injection therapy voluntarily to assist with certain symptoms or ailments I may be experience.

_____ I have informed (Insert clinic name, your name, nurses name) of all the medications, supplements, and allergies that I have. I understand that serious adverse events could happen if I do not disclose all of my drug/food/vitamin/and additional allergies and medications/supplements that I am currently taking.

_____ I understand that IV and injectable therapy and any claims made about these treatments 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. I understand that these treatments are not FDA approved for any given indications of treatment and are not considered a medical necessity.

_____ I understand that I have been informed of the procedure involving IV infusion and injections, the alternative treatment options, and the risks and benefits of the mutually agreed upon treatment.

_____ I understand that the procedure involves inserting a needle into a vein or having a solution injected into my muscle or body fat.

_____ I understand that common risks involved with IV and injection therapies include, but are not limited to, irritation, pain, discomfort, bruising, and bleeding at the site of the IV insertion or injection.

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_____ I understand that less common risks involved with IV and injection therapies include, but are not limited to, infection at the site of the IV insertion or injection, injury to the tissue, phlebitis, low blood pressure, fainting, fluid volume overload, medication interactions, and drops in blood sugar levels.

_____ I understand that rare side risks involved with IV and injection therapies include, but are not limited to, sepsis, severe allergic reactions, severe medication/supplement interactions, anaphylaxis, blood clots, shock, cardiac arrest, and death.

_____ I understand that the benefits of IV and injection therapies include, but are not limited to, enhanced absorption of vitamins and minerals as they bypass the digestive tract, increased total body hydration, alleviation of certain symptoms, increased total body nutrient density, and improved performance/recovery.

_____ I affirm that I am voluntarily seeking IV infusion and injection therapies at Professional Concierge Nursing and have not been coerced into doing so.

_____ I understand the risks and benefits of the procedure, IV infusion therapy, and injection therapy and have had all my questions answered to my full satisfaction.

_____ I understand that unforeseeable complications can arise when an IV is placed and medications/fluids/minerals/vitamins are infused into the body.

_____ I understand that I have the right refuse any treatments or treatment recommendations at any time.

Voluntary Nature of Treatment and Alternative Therapies

Treatment with IV and injectable vitamins/hydration/nutritional/mineral and/or medications offered at Professional Concierge Nursing is completely voluntary in nature. Alternative therapy for the symptoms you are seeking IV infusion and injectable therapy for include, not are not limited to, ongoing treatment by your primary care provider and/or specialty provider, oral supplementation, and dietary/lifestyle modifications.

I acknowledge that IV infusion and injection therapy provided at Professional Concierge Nursing is voluntary in nature and that I am seeking out this therapy on my own or from the recommendation of my referring provider. I acknowledge that I have also notified my medical and/or mental health provider about my decision to undergo IV and injectable vitamin/hydration/nutritional/mineral therapy. I acknowledge the alternative treatment options and have voluntarily decided to pursue IV and injectable therapy.

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Signature _____
Date_____

Final patient consent for treatment.

- I have had the nature of the procedure and/or treatment, the benefits of treatment, the risks of treatment, the side effects, the alternative therapies for my medical condition or symptoms I am seeking treatment for, and the chances of treatment success explained to me. I have had all my questions and concerns answered to my satisfaction. I acknowledge that I have been given sufficient information about IV hydration/vitamin/mineral/nutrient infusion and injection therapy and all its associated risks and benefits upon which to make an informed decision about treatment.
- I acknowledge that there are no guarantees regarding the results of treatment and its effect on my presenting condition.
- I give my consent for the use of emergency intervention if required during treatment.
- I certify that I am of sound mind and body to make medical decisions and to consent for treatment.
- I certify I will continue to remain under the care a licensed and qualified primary care provider and/or mental health provider as IV infusion and injection therapy is considered an adjunctive and non-medically necessary treatment option, not a complete one.
- I release Regina Speights, DNP, FNP-C at PROFESSIONAL CONCIERGE NURSING and all the medical staff from all liabilities for any complications or damages associated with IV infusion and injection therapy.
- I have read this consent and fully understand the information within it and I voluntarily authorize and consent to the treatment options, including but not limited to IV infusion therapy, provided to me at PROFESSIONAL CONCIERGE NURSING.

Signature _____
Date_____

Lipotropic Injection and B12 Informed Consent

Name:_____

Lipotropic injections aid in weight loss by increasing your metabolism. Vitamin B-12 helps maintain optimal health and has been shown to be beneficial in helping to reduce fatigue, improve memory, and maintain a healthy body weight. It is what your body uses to help create energy, which is one of the reasons people feel more energized when they take B12.

While all components of a lipotropic injection generally have no side effects, you need to remember that all medications and supplements have potential side effects, including B12, methionine, inositol, choline, and amino acids. Most people tolerate B12 and lipotropic injections without issue as side effects are rare.

Potential common B12 side effects include, but are not limited to: mild diarrhea, upset stomach, nausea, pain at the injection site, swelling, headache and joint pain.

Potential common lipotropic injection side effects include, but are not limited to: stomach upset, diarrhea, urinary frequency/urgency/hesitancy, fatigue, elevated heart rate, and restlessness.

You acknowledge:

1. That if I begin to have side effects, I will contact Professional Concierge Nursing and Regina Speights, DNP, FNP-C immediately and notify them of what is happening.

2. I understand that although rare, vitamin B12 injections can result in serious side effects. If these occur, you should follow up with a medical provider or go to the emergency department immediately. Uncommon and dangerous side effects include: rapid heartbeat, chest pain, flushed face, muscle cramps, weakness, difficulty breathing and swallowing, dizziness, confusion, rapid weight gain, feeling of tightness in the chest, hives and rashes, shortness of breath when there is no physical exertion and unusual wheezing and coughing.

3. Before starting vitamin B12 and lipotropic injections I agree to make Professional Concierge Nursing and Regina Speights, DNP, FNP-C aware if I have any of these conditions: Leber's Disease, liver disease, kidney disease, iron deficiency, folic acid deficiency, cardiovascular disease, receiving any treatment or taking any medication that has an effect on bone marrow, or drug/supplement allergies.

4. I understand that there could be interactions with B12 and lipotropic injections and certain medications/supplements.

5. The use of B12 and lipotropic injections on a weekly to biweekly basis without a documented B12 deficiency is considered off label use and has not been FDA approved for increasing energy levels and weight loss.

5. Caution is advised while taking B12 if you have a sulfa allergy.

Lipotropic Injection and B12 Informed Consent

By signing below, I acknowledge that I have read the informed consent and agree to the treatment with its associated risks. I hereby give consent for B12 and/or lipotropic injections. I agree to inform my medical provider immediately if I have any side effects. I hereby release Professional Concierge Nursing and Regina Speights, DNP, FNP-C and the person injecting the B12 and lipotropic injection of any damages or liability if anything was to occur.

Patient Signature_____ Date: _____