Informed Consent for B Vitamin and Lipotropic Injection Therapy

This document is intended to serve as confirmation of informed consent for injection therapy such as ordered by Dr. Wolins.

I have informed Dr. Wolins of any known allergies to drugs or other substances, or of any past reactions to injections. I have informed the doctor of all my medical conditions and current medications. I understand that I have the right to be informed of the procedure, any feasible alternative options, and the risks and benefits. Except in emergencies, procedures are not performed until I have had an opportunity to receive such information and to give my informed consent.

I understand that:

1. The procedure involves inserting a needle into various areas of the body and injecting of vitamins and other homeopathic remedies.
2. Risks of injection therapies include but are not limited to:
   a. Occasionally to commonly:
      • Discomfort, severe pain, bruising, inflammation, injury and numbness at the site of injection.
      • Fatigue, dizziness, or light-head feeling after the injections.
      • Fainting or loss of consciousness during the procedure.
   b. Extremely rare:
      • Severe allergic reaction, anaphylaxis, infection.

I am aware that other unforeseeable complications could occur. I do not expect the physician to anticipate and or explain all risk and possible complications. I rely on the physician to exercise judgement during the course of treatment with regard to any procedure. I understand the risks and benefits of the procedure and have had the opportunity to have all of my questions answered. I understand that I have the right to consent to or refuse any proposed treatment at any time prior to its performance. My signature on this form affirms that I have given my consent to injection therapy with any different or further procedures which, in the opinion of Dr. Wolins, may be indicated.

My signature below confirms that:

1. I understand the information provided on this form and agree to the foregoing.
2. The procedure(s) set forth above has been adequately explained to me by Dr. Wolins.
3. I have received all the information and explanation I desire concerning the procedure.
4. I authorize and consent to the performance of the procedure(s).

____________________________  __________
Patient Name (Please Print)      Date

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Patient Signature