Patient Registration, Information and Consent Form

THE NECTAR NUTRITION

Name:		Date:
Address:		Sex: M F
City/State:	Zip:	Date of Birth:
Email:		Age:
Primary Phone:		Height:
How did you hear about us?		
Name/phone of emergency contact:		

IV Treatments (please select one)

	The Nectar ELITE	$300
	The Nectar Lite	$175
	Immune Boost	$150
	The Apollo	$200
	Beauty Bag	$200
	Mighty Aphrodite	$200
	Weekend Warrior	$200
	The Marathon	$200
	Recover/Hang Over	$200
	Chelation	$600

Add On's

	UBI	$150
	MAH	$150
	Glutathione	$80
	Vitamin C	$80

Injectables

	Procaine	$80
	Vitamin B	$80
	Prolozone	$80
	NAD+	$80

Not sure which treatment is best for you? Leave the IV selections portion blank and one of our providers can review your symptoms/medical history with you to make a recommendation that may be best based on their expert knowledge.

Please let the providers know of any conditions that may affect the treatment such as fainting or vomiting from needle sticks.

Medical History

	No	Yes	Date
Heart Disease (Heart attacks, murmurs)			
Kidney or Bladder Disease			
High Blood Pressure			
Blood Clot Disorder			
Thyroid Disease			
Cancer			
Strokes or Paralysis			
High Blood Cholesterol			
Anxiety / Depression			
Stomach Disorder			
Epilepsy / Seizures			
Gall Bladder Disease			
Liver Disease (cirrhosis, hepatitis, jaundice)			
Lung Disease (asthma, tuberculosis)			
Anemia or other blood disorder			
Diabetes			
Skin Disorder (unusual or recently changed moles)			
Glaucoma or other eye disorder			
Rheumatic Fever			
Anorexia / Bulimia			
Arthritis			
Hemochromotosis			
G6PD			

Are you Pregnant?

Yes No

Have you taken any pain medication today?

Yes No

Drug and Food Allergies

Drug/Food	Reaction

Daily Medications

Name of Medication	Daily Dosage

Office use only.

Date: _____

Heart Rate: _____

Blood Pressure: _____

Notes: _____

Patient Registration and Information Consent Form

I, _____(patient) authorize The Nectar to assist me in intravenous therapy. I understand that The Nectar is treating my symptoms and is not making any medical related diagnosis. I understand that this procedure may be considered medically unnecessary. It may or may not mitigate, alleviate, or cure the condition for which it is being prescribed. I understand it is my responsibility to list any and all health history and medications currently being taken. I understand that The Nectar, practitioners and medical staff, take every precaution to decrease any risk of health related complications associated with Inter Muscular Injections and/or IV administration, but there is still an extremely low risk of complications including but not limited to: infection at IM/IV site; pain, swelling, or burning around IM/IV site; Phlebitis; Bruising or injury from vein puncture; Anaphylaxis or other life threatening reactions. I understand that with extreme dehydration intravenous access may be more difficult, resulting in the inability to administer IV fluid. I understand that payment is due in full at the time of service, The Nectar does not bill insurance companies on your behalf.

Patient Signature: _____ Date: _____

Acknowledgement of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to: • Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly • Obtain payment from third party payers for my health care services • Conduct normal healthcare operations such as quality assessment and improvement activities I have been informed of my medical provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my medical provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations and I understand that you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

Patient Name: _____ Date: _____