Patient Name_____ Patient DOB_____

INFORMED CONSENT FOR IV METHYLENE BLUE

I acknowledge that I have been informed about the administration of Methylene Blue via intravenous (IV) route. I understand the purpose, benefits, and potential risks associated with this procedure. I have had the opportunity to ask questions, and any concerns I raised have been addressed to my satisfaction.

Purpose: Methylene Blue is being administered to address mitochondrial function and oxidative stress. Its primary purpose is to restore oxygen-carrying capacity of blood and anti-viral purposes.

Benefits:

- Restoration of normal oxygen levels in the blood.
- Improvement in blood pressure and circulation.
- Treatment of mitochondrial function
- Decrease Oxidative Stress
- Anti-viral
- Neuroprotective

Potential Risks and Side Effects: While Methylene Blue is generally considered safe when administered under medical supervision, there are potential risks and side effects associated with its use, including but not limited to:

- Hypotension: Methylene Blue may cause a drop in blood pressure, leading to dizziness or fainting.
- Methemoglobinemia: In rare cases, Methylene Blue may paradoxically exacerbate methemoglobinemia, a condition characterized by reduced oxygen-carrying capacity of the blood.
- Serotonin Syndrome: Individuals taking certain medications, particularly antidepressants such as selective serotonin reuptake inhibitors (SSRIs), may be at risk of developing serotonin syndrome when combined with Methylene Blue.
- Allergic Reactions: Some individuals may experience allergic reactions, ranging from mild rash to severe anaphylaxis.

Contraindications

I understand that it has been advised that I should not receive this therapy if I have the following conditions:

- Misuse of or dependency on any drug
- Currently pregnant or lactating or are planning to become pregnant in the next 12 months
- Known allergy or intolerance to **Methylene Blue** or any of its other contents
- **Currently on any SSRI**
- G6PD Deficiency
- Severe Hypertension

This procedure may be considered medically unnecessary. It may or may not mitigate, alleviate, or cure the condition for which it has been prescribed. This therapy has been recommended to you in the belief that it is of potential benefit in these circumstances and its use will quite probably improve the condition for which you are under treatment and in your overall health.

Based on the risks and potential benefits of the current medically indicated treatment(s) and of this proposed treatment, I have elected to forego or supplement the indicated treatment(s) and receive this proposed treatment from the health professionals at Yoo Direct Health, as is appropriate and necessary for my care.

I understand that my treatment records and test results may be used as the basis for a published study and consent to such use of my treatment results. I further understand and agree to adhere to the treatment schedule and attend the follow-up visitations set by my medical provider to permit observation and study of my progress. I understand that I may suspend or terminate my treatment at any time by informing my medical provider. I assume full liability for any adverse effects that may result from the non-negligent administration of the proposed treatment. I waive any claim in law or equity for redress of any grievance that I may have concerning or resulting from the procedure, except as that claim pertains to negligent administration of this procedure. The risks involved and the possibilities of complications have been explained to me. I fully understand and confirm that the nature and purpose of the aforementioned treatment to be provided may be considered unproven by scientific testing and peer-reviewed publications and therefore may be considered medically unnecessary or not currently indicated.

I hereby place myself under your care for intravenous neural therapy and agree to the above release. I also verify that all information presented to medical provider in my medical history is true to the best of my knowledge. I am not misrepresenting myself and I place myself under your care for the sole purpose of treatment for these conditions.

I hereby acknowledge that I understand that my Insurance coverage, including Medicare, may not pay for this non-covered service, and that all services ancillary to this treatment may be also non-covered services and non-reimbursable. I agree to be responsible for payment at the time of service for all services, including non-covered services.

NAME _____

SIGNATURE X_____ **DATE** _____

Relationship to Patient (if signed by legal representative) _____

Please provide authority to sign document