Patient Name_____ Patient DOB_____

INFORMED CONSENT FOR IV PROCAINE/NEURAL THERAPY

I authorize the administration of intravenous Procaine. Procaine is a local anesthetic that was created in 1905 and in 1925 was first administered intravenously. Neural therapy has been widely practiced by medical community in Europe and Latin America.

This procedure has an anti-inflammatory and antioxidative effect to harmonize the entire nervous system of the body. This can reduce existing pain and restore the nervous system sensitized to chronic pain back to a normal state of stimulation.
IV Procaine/neural therapy is an application that can be used to support or even cure a number of chronic diseases such as:

- Acute and chronic pain
- Inflammation Inhibition
- Degenerative diseases (rheumatic diseases, fibromyalgia, migraines, neuralgias, gout)
- Gastrointestinal disorders
- Lung, heart, and kidney diseases
- Chronic diseases of the tonsils, sinuses, and teeth
- Circulatory disorders
- Osteoarthritis

Side effects with IV Procaine are very rare. Possible side effects that may accompany intravenous administration of neural therapy include:

- burning and stinging at the site of infusion or if IV infiltrates into surrounding tissue
- muscular spasms, weakness, or fatigue
- allergic reactions (rare)
- heart palpitations
- sweating
- hyperactive feeling for up to 24 hours after infusion
- Temporary Headache
- Temporary feeling of slight impairment during infusion- this will subside at the end of the IV treatment

I am aware that I am required to stay in the office for monitoring until I have been released to drive.

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