**MEDICAL INFORMED CONSENT**

for Authorization for Intravenous Procaine Administration

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize the administration of intravenous Procaine. Procaine is a local anesthetic created in 1905 and first administered intravenously in 1925. Neural therapy, utilizing Procaine, is widely practiced in Europe and Latin America and growing in the US.

This procedure has anti-inflammatory and antioxidative effects aimed at harmonizing the entire nervous system. It can reduce existing pain and restore a nervous system sensitized to chronic pain to a normal state.

Intravenous Procaine/neural therapy can support or potentially restore to health, various chronic diseases, including:

* Acute, chronic and phantom pain
* Inflammation inhibition
* Mood disorders (anxiety, depression, OCD, PTSD)
* Drug or substance abuse
* 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 may include:

* Burning and stinging at the infusion site or if IV infiltrates surrounding tissue
* Muscular spasms, weakness, or fatigue
* Allergic reactions (rare)
* Heart palpitations
* Sweating
* Hyperactivity for up to 24 hours after infusion
* Temporary headache
* Temporary feeling of slight impairment during infusion, which will subside after 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 in the belief that it is of potential benefit and may improve the condition for which I am being treated and my overall health.

Based on the risks and potential benefits of the current medically indicated treatments and this proposed treatment, I have elected to forego or supplement the indicated treatments and receive this proposed treatment from the health professionals at [Practice Name], as appropriate and necessary for my care.

I further understand and agree to adhere to the treatment schedule and attend follow-up visits 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 my 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 acknowledge that my insurance coverage, including Medicare, may not pay for this non-covered service and that all services ancillary to this treatment may also be 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient (if signed by legal representative): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_