Vitae Health Center
16521 13th Ave West, Ste. 105, Lynnwood, WA 98037 (425) 742-3800
vitality, naturally

Injection Therapy Informed Consent

This document is intended to serve as confirmation of informed consent for injection therapy such as superficial or deep injections as ordered by the physician at Vitae Health Center.

(Initials)___________ I have informed the physician of any known allergies to drugs or other substances, or of any past reactions to anesthetics. I have informed the doctor of all current medications and supplements.

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 procaine and other homeopathic remedies.
2. Risks of injection therapies include but are not limited to:
    a. Occasionally to commonly:
        i. Discomfort, severe pain, bruising, inflammation, injury and numbness at the site of injection.
        ii. Fatigue, dizziness, or light-head feeling after the injections.
        iii. Fainting or loss of consciousness during the procedure.
    b. Extremely Rarely:
        i. Severe allergic reaction, anaphylaxis, infection, cardiac arrest and death.

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 judgment during the course of treatment with regards 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 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 my physician, may be indicated.

Dr. Susan H. Mueller
16521 13th Ave. West, Lynnwood, WA 98037
(425) 742-3800

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 my physician.
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's Name – Please Print Date

______________________________ ____________________

Patient's Signature Date

______________________________ ____________________

Physician's Name – Please Print Date

______________________________ ____________________

Physician's Signature Date

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