(Zola Vitality Spa LLC) Clinical Policies

PATIENT CONSENT FOR IV INFUSION AND INJECTION THERAPIES WITH (Zola Vitality Spa LLC).

If you have any questions, please feel free to ask us. Please initial each point acknowledging you understand that:

_____ If you are late or miss your appointment, you may be subject to a $50 fee.

_____Services must be paid for at the time of service.

_____Health insurance typically does not cover services provided at (Zola Vitality Spa LLC). If you want to seek insurance reimbursement, we would be happy to provide you itemized invoices that you can submit to your insurance company.

_____Since each insurance company has its own policies regarding the coverage of procedures, I also acknowledge that I am responsible for payment in full for the charges incurred for procedures and treatment regardless of the coverage provided by my insurance carrier.

_____I understand that treatments used at (Zola Vitality Spa might not be considered a medical necessity. Treatments rendered are for the purpose of improving your quality of life.

_____ I agree that if I am having any side effects or become sick, that I will follow up with my primary care provider or go to an urgent care or emergency department.

_____I acknowledge that (Zola Vitality Spa LLC) and (Katherine Adelufosi APRN) are not my primary care provider. I agree that I will continue with routine care through my primary care provider and notify them of treatments prescribed and performed at (Zola Vitality Spa LLC).

_____I understand that there are no refunds for services or products rendered.

_____I understand that having an appointment with (Zola Vitality Spa LLC) does not necessarily entitle me to having an IV infusion or injection procedure performed. Every individual is different, and it is at the medical providers discretion to issue treatment.

_____I understand that I must maintain my follow up appointments and following post procedural care instructions to remain on treatment. It is important that (Katherine Adelufosi APRN) manages my treatment and it is at their discretion to provide me ongoing therapies if desired.

_____I acknowledge that I have been advised of the risks and benefits of treatment. I also acknowledge that I have been advised of possible complications and side effects. I understand the risks, benefits, complications, and side effects of treatment.

_____I am voluntarily requesting treatment with (Zola Vitality Spa LLC) and (Katherine Adelufosi APRN) in regard to IV infusion therapy and injection therapy as determined by a mutual decision between myself and the medical provider even if it is not considered a medical necessity.

_____I do not hold any medical practitioner of (Zola Vitality Spa LLC) responsible for performing age-related preventive care. I agree that I will follow up with my primary care provider to obtain these screenings and I hold (Zola Vitality Spa LLC) and (Katherine Adelufosi APRN) harmless if an adverse event occurs during my treatment.

I have read, understand, and agree to all of the above statements.

Print Name: _____

Signature: _____ Date: _____