

B R A V O U R E

## **Bravoure Medical Wellness Clinical Policies**

*PATIENT CONSENT FOR IV INFUSION AND INJECTION THERAPIES WITH BRAVOURE MEDICAL WELLNESS.*

**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 Bravoure Medical Wellness. If you want to seek insurance reimbursement, we would be happy to provide you itemized invoices that you can submit to your insurance company.

\_\_\_\_\_ I understand that treatments used at Bravoure Medical Wellness might not be considered a medical necessity. Treatments rendered are for the purpose of improving your quality of life.

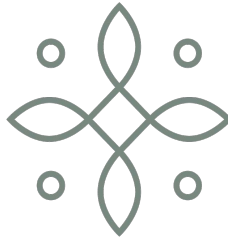
\_\_\_\_\_ I agree that if I am having any side effects or become sick, that I will follow up with my primary care provider or go to an urgent care or emergency department.

\_\_\_\_\_ I acknowledge that Bravoure Medical Wellness and Christine Carter, DNP, FNP-C 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 Bravoure Medical Wellness.

\_\_\_\_\_ I understand that there are no refunds for services or products rendered.

\_\_\_\_\_ I understand that having an appointment with Bravoure Medical Wellness 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 Christine Carter, DNP,



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FNP-C 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 Bravoure Medical Wellness and Christine Carter, DNP, FNP-C 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 Bravoure Medical Wellness 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 Bravoure Medical Wellness and Christine Carter, DNP, FNP-C 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 \_\_\_\_\_