



I, \_\_\_\_\_, hereby give my voluntary consent to receive intravenous (IV) nicotinamide adenine dinucleotide (NAD) followed by optional Nutrient IV at HDR8 – Hydration Therapy. The procedure is to be administered by the licensed staff of HDR8 – Hydration Therapy. NAD Therapy is a comprehensive amino acid, vitamin, and mineral treatment given for a variety of conditions. These amino acids, vitamins, and minerals are primarily administered through an IV.

I FULLY UNDERSTAND AND AM FULLY AWARE THAT:

\_\_\_\_\_ The desired effect, improvement, or relief of any condition for which NAD Therapy is to be applied may or may not be attained. Moreover, NAD Therapy does not preclude the need for other forms of therapy and I assume full responsibility for the treatment of my condition by other physicians practicing standard medicine, as may be deemed necessary for my well-being.

\_\_\_\_\_ There may be complications resulting from this procedure which could include but are not limited to infection, nausea, vomiting, diarrhea, pain and discomfort, weakness, fainting, micro-hemorrhages, ecchymosis, embolism, allergic reactions, shock, IV fluid infiltration, swelling, needle breakage and its retention, death, and even aggravation of current symptoms. Most patients report mild symptoms during the administration of NAD and the vitamin mixture that are transient.

\_\_\_\_\_ No assurances or guarantees have been made, nor can any be made concerning the results that may be obtained, but the physicians and nurses who will provide the treatment which I will undergo will perform their services, and take such precautions that are consistent with the standards of care that prevail for the same type of treatment provided to patients with conditions similar to mine.

By signing this consent form, I have not waived any of my legal rights or released this institution from liability for negligence. I also understand that I may revoke my consent at any time and withdraw from any further treatment without prejudice.

My signature below confirms that:

- I understand the information provided on this form and agree to the foregoing.
- The procedure(s) set forth above has been adequately explained to me by my nurse/physician.
- I have received all the information and explanation I desire concerning the procedure.
- I certify that I am not pregnant.
- I certify that I am not intoxicated on alcohol or any illicit drugs.
- I authorize and consent to the performance of the procedure(s).

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Signature of Patient or Legal Guardian

Date

Clinic Name

Address

Phone, Fax