# SKIN-LOUETTE LLC

## Comprehensive Informed Consent for IV Therapy & Wellness Services

*Luxury Aesthetics & Wellness · Atlanta, GA Mobile concierge IV therapy services provided at client-selected locations*

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**Client Full Name: _____ Date of Birth: _____ Date of Service: _____ Session Location: _____ Service(s) Requested: _____ RN Administering: _____**

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## PART A — GENERAL IV THERAPY CONSENT

### A1 — Description of Service

I understand that Skin-Louette LLC provides mobile concierge IV therapy and wellness injection services delivered at my selected location. All services are administered by a licensed Registered Nurse (RN) under physician medical direction pursuant to standing orders issued by a licensed Georgia physician.

IV therapy involves the intravenous administration of fluids, vitamins, minerals, amino acids, and/or other wellness compounds directly into my bloodstream via a peripheral intravenous catheter. Wellness shots involve the intramuscular (IM) injection of vitamins and/or wellness compounds.

### A2 — General Risks & Side Effects

I understand and acknowledge that IV therapy and wellness injections carry potential risks and side effects including but not limited to:

**Common/Minor:** □ Bruising, soreness, or redness at the IV or injection site □ Swelling or hematoma at the insertion site □ Mild discomfort during insertion □ Feeling of warmth, flushing, or tingling during infusion □ Mild headache or lightheadedness □ Nausea or

stomach discomfort □ Metallic taste in the mouth □ Temporary cooling sensation in the arm

**Uncommon:** □ Phlebitis (inflammation of the vein) □ Infiltration (fluid leaking outside the vein) □ Vasovagal reaction (fainting) □ Infection at the IV site □ Elevated blood pressure or heart rate □ Chest tightness or shortness of breath □ Muscle cramping or spasms

**Rare but Serious:** □ Allergic reaction or anaphylaxis □ Air embolism □ Pulmonary edema □ Severe electrolyte imbalance □ Thrombosis (blood clot) □ Vein irritation, phlebitis, or in rare cases vein scarring from repeated IV access at the same site

**Results Disclaimer:** I understand and acknowledge that **individual results are not guaranteed**. IV therapy and wellness injections support general wellness and may produce different results for different individuals. No specific health outcomes, skin results, energy levels, or therapeutic benefits are promised or guaranteed by Skin-Louette LLC or its supervising physician.

**Emergency Escalation Authorization:** I hereby authorize Skin-Louette LLC and its licensed RN to contact emergency medical services (911) on my behalf if, in the professional clinical judgment of the RN, my condition requires emergency medical intervention during or immediately following my session. I understand that:

- The RN will always prioritize my safety above all else
- Emergency services may be called without my explicit consent if I am unresponsive or unable to consent
- All emergency actions will be documented in my client chart
- I release Skin-Louette LLC from liability for any costs associated with emergency medical services called in good faith for my safety

**I understand that if I experience any concerning symptoms during or after my session I should notify the RN immediately and seek emergency medical care by calling 911 if necessary.**

## A3 — Client Representations

I confirm the following:

□ I have accurately and completely disclosed my full medical history on the intake form □ I have NOT withheld any medical information relevant to my safety □ I am 18 years of age or older □ I understand these services are for general wellness purposes only and are not intended to diagnose, treat, cure, or prevent any disease or medical condition □ I understand individual results may vary and no specific outcomes are guaranteed □ I have had the opportunity to ask questions and received satisfactory answers □ I have eaten within the last 2-4 hours and am adequately hydrated

**Client Initials: _____ Date: _____**

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# PART B — SPECIFIC INGREDIENT CONSENTS

*Initial each section that applies to your session today.*

## B1 — Glutathione Consent

I understand and consent to the administration of Glutathione as part of my IV therapy session.

**I have been informed that:**

- Glutathione is a powerful antioxidant administered at high doses (up to 1,200mg) in The Louette Glow drip
- It is used for skin brightening, antioxidant support, and toxin elimination
- High-dose glutathione is inspired by protocols used in Korean luxury wellness clinics
- Possible side effects include temporary flushing, tingling, skin changes, and in rare cases allergic reaction
- Glutathione is **contraindicated in clients with G6PD deficiency**
- I confirm I do **NOT** have known G6PD deficiency
- Results vary by individual and multiple sessions may be needed for visible results

**Client Initials: _____ Date: _____**

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## B2 — NAD⁺ (Nicotinamide Adenine Dinucleotide) Consent

I understand and consent to the administration of NAD⁺ as part of my La Belle IV therapy session.

**I have been informed that:**

- NAD⁺ is administered at **250mg** per La Belle session
- NAD⁺ works at the cellular level supporting DNA repair, energy production, and cellular rejuvenation
- NAD⁺ **MUST be administered slowly** — my session will take **90-120 minutes minimum**

- Rapid infusion of $NAD^+$ causes uncomfortable side effects — the slow rate is non-negotiable for my safety
- **Common $NAD^+$ side effects include:** flushing, nausea, chest tightness, muscle cramping, and palpitations — these are typically related to infusion rate and resolve when rate is slowed
- I will notify my RN IMMEDIATELY if I experience chest tightness, severe nausea, or significant discomfort
- The RN will slow or pause the infusion as needed for my comfort
- I have planned a minimum 2-hour appointment and understand I cannot rush this session
- $NAD^+$ is **contraindicated** in clients with active cancer (consult physician) and may require caution in pregnancy
- I confirm I have disclosed any relevant medical conditions on my intake form

**Client Initials: _____ Date: _____**

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## B3 — High-Dose Vitamin C Consent

I understand and consent to the administration of high-dose Vitamin C as part of my IV therapy session.

**I have been informed that:**

- High-dose Vitamin C (up to 10,000mg) is administered in certain drips including The Louette Glow and The Shield
- At high doses Vitamin C provides powerful antioxidant and immune support benefits
- Possible side effects include nausea, GI discomfort if infused too rapidly, and in rare cases kidney stones in susceptible individuals
- High-dose Vitamin C is **contraindicated in clients with G6PD deficiency**
- I confirm I do **NOT** have known G6PD deficiency
- I have disclosed any history of kidney stones on my intake form

**Client Initials: _____ Date: _____**

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### B4 — Magnesium Consent

I understand and consent to the administration of Magnesium as part of my IV therapy session.

**I have been informed that:**

- Magnesium is administered in several drips for energy, muscle, and nervous system support
- Common side effects include a warm flushing sensation, temporary low blood pressure, and mild drowsiness
- I will notify my RN if I feel faint, dizzy, or extremely warm during my session
- I have disclosed any cardiac conditions on my intake form

**Client Initials: _____ Date: _____**

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### B5 — Prescription Medication Consent (if applicable)

*Complete only if prescription medications (Zofran/Toradol) are being administered today.*

I understand and consent to the administration of the following prescription medication(s):

□ **Ondansetron (Zofran) 4mg IV** — for nausea/vomiting □ **Ketorolac (Toradol) 15-30mg IV** — for pain/inflammation

**I have been informed that:**

- These are prescription medications administered ONLY upon direct physician order
- Zofran may cause headache, dizziness, and in rare cases QT prolongation
- Toradol is an NSAID anti-inflammatory contraindicated with blood thinners, kidney disease, GI conditions, and pregnancy
- I have disclosed all current medications and conditions on my intake form
- A physician has been directly consulted and has authorized this medication for me today

**Physician who authorized: _____ Time: _____**

**Client Initials: _____ Date: _____**

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## PART C — PHOTOGRAPHY & SOCIAL MEDIA CONSENT

*Please select ONE option below:*

**Option 1 — Full Consent:** □ I consent to Skin-Louette LLC photographing or recording my session including my face and likeness for educational and/or marketing purposes including social media. I understand I will be notified before any photos are taken.

**Option 2 — Partial Consent:** □ I consent to Skin-Louette LLC photographing or recording my session for marketing purposes. I do NOT consent to images showing my face or identifying features. Images may show hands, arms, IV setup, and general session environment only.

**Option 3 — No Consent:** □ I do NOT consent to any photography or recording of my session or person for any purpose.

*Note: Selecting Option 3 will never affect the quality of care you receive.*

**Client Initials: _____ Date: _____**

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## PART D — CANCELLATION & NO-SHOW POLICY

I have read and agree to the following Skin-Louette cancellation and no-show policy:

**Deposits:**

- A deposit may be required at time of booking to secure your appointment
- Deposit amount will be communicated at time of booking

**Cancellations:**

- Cancellations made **more than 24 hours** before your appointment: full deposit refund or credit
- Cancellations made **less than 24 hours** before your appointment: deposit forfeited — no refund
- Same-day cancellations: deposit forfeited — no refund

**No-Shows:**

- Clients who do not show for their appointment without prior notice will forfeit their deposit
- Repeat no-shows may be required to pay in full at time of booking for future appointments

**Late Arrivals:**

- Arriving more than 15 minutes late may result in a shortened session or rescheduling at RN discretion
- Full session fee applies regardless of late arrival

**Medical Emergencies:**

- We understand emergencies happen — please contact us as soon as possible
- Medical emergencies will be handled with compassion on a case-by-case basis

**All sales are final.** Refunds are not provided for completed services.

**Client Initials: _____ Date: _____**

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## PART E — GENERAL RELEASE & FINAL ACKNOWLEDGMENT

By signing below, I acknowledge that:

1. I have read and understand this entire informed consent document in full
2. I have had the opportunity to ask questions — all questions have been answered to my satisfaction
3. I voluntarily consent to receive the requested IV therapy and/or wellness injection services from Skin-Louette LLC
4. I understand all risks involved and accept personal responsibility for my decision to proceed
5. I release Skin-Louette LLC, its owner, employees, and supervising physicians from liability for complications arising from undisclosed medical conditions or medications
6. I confirm all information I have provided on my intake form is accurate and complete
7. I understand that Skin-Louette provides mobile concierge services and I have authorized the session location
8. I consent to Text/SMS communication for appointment reminders and care instructions per my selection on the intake form
9. I have received and agree to the Skin-Louette Client Experience & Concierge Policy
10. This consent is valid for **12 months** from the date of signature — a new consent will be required annually or if my medical history changes significantly

**Client Signature: _____ Date: _____**

**Printed Name: _____**

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*If client is under 18 years of age:*

**Parent/Guardian Signature: _____ Date: _____**

**Printed Name: _____ Relationship: _____**

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**RN Witness Signature: _____ Date: _____**

**RN Printed Name: _____ RN License #: _____**

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*Skin-Louette LLC · Luxury Aesthetics & Wellness · Atlanta, GA Mobile concierge IV therapy services provided at client-selected locations hello@skinlouette.com · skinlouette.com · (470) 408-5090*