IV Therapy Policy – Cairn Medical Group

Our policies and requirements for receiving IV Therapy are listed below. We ask that you read these policies carefully and follow them so that you may have a successful, smooth experience when you come to your IV Therapy appointment. Failure to follow these guidelines when coming to your IV Therapy appointment may result in being unable to complete the scheduled treatment; repeated failure to follow these guidelines such that we are unable to complete treatment may result in a cancellation fee being assessed at the time of the visit.

1. Please be on time to your IV Therapy appointment.
2. If you need to cancel your IV Therapy appointment for any reason, please provide our office with at least 24 hours' notice. We reserve the right to charge a cancellation/no-show fee for appointments canceled with less than 24 hours' notice or for appointments for which you do not show up.
3. Please be prepared for your treatment. This includes being well hydrated and please make sure that you have eaten a meal with protein; please do not come fasting.
4. Payment for IV Therapy is due at the time of your visit. We recommend placing a card on file with us, so that we may charge it at the time of service without needing you to pull out your card each time—leaving a card on file with us streamlines your experience in the office.
5. Understand that IV Therapy is not billable to insurance through our office; IV Therapy is very rarely covered by insurance.

I have read and understand the policies outlined above; I agree to follow them and understand the possible consequences should I choose not to do so.

Patient Signature Printed Name Date

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX □ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I,_____, authorize Cairn Medical Group to charge my credit card above for agreed upon IV Therapy charges, supplement purchases and office visit copays. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date