INCREDIBLE HEALTH
HEALTHY AND STRONG TM

Informed Consent for Peptide Therapy

I seek the medical services of Incredible Health, LLC and their employees (collectively Incredible Health). I am executing this consent to confirm my discussion with Dr. Toni Harrison and my understanding of the risks, benefits, and alternatives to treatment with peptide therapy. The goal and possible benefits of this therapy are to try and prevent, reduce or control the dysfunction associated with the aging process, through hormonal balancing, control of oxidative stress, and other clinically significant therapeutic agents. However, I understand that this treatment may be viewed by the mainstream medical community as new, controversial, off-label, experimental, and unnecessary by the Food and Drug Administration ("FDA").

By signing this form, I understand the possible risks associated with this treatment. Adverse reactions include injection site redness, transient high blood sugar, development of antibodies and water retention. These side effects are dose related and usually eliminated by adjusting the dosage. This type of therapy should not be used in patients with known cancer.

I understand that my treatment will be prescribed in an effort to prevent any side effects but cannot be guaranteed that I will not experience any side effects or adverse reactions. I understand that, as with any health treatment, there is no guarantee I will obtain satisfactory results through the use of this therapy. I understand the use of this treatment does not preclude me from using other treatments as well, though I recognize that I should inform any practitioners I am seeing about the various treatments I am using.

NOTE: DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING THIS FORM. DO NOT SIGN THIS FORM IF YOU HAVE TAKEWN MEDICATIONS WHICH MAY IMPAIR YOUR MENTAL ABILITIES OR IF YOU FEEL RUSHED OR UNDER PRESSURE. PEPTIDE THERAPY IS ALWAYS OPTIONAL.

I certify that I have read the foregoing Informed Consent, discussed the issues noted above, had opportunities to ask questions, and agree and accept all of the terms above.

CLIENT NAME: _____

CLIENT SIGNATURE: _____ DATE: _____

I have explained this Informed Consent and answered all questions and informed the patient of the available alternatives and of the potential risks. To the best of my knowledge, the patient has been adequately informed and has consented.

PHYSICIAN SIGNATURE: _____

WITNESS SIGNATURE: _____