Dr. Jodi Berg
Integrative Family Health Clinic

INFORMED CONSENT FOR PEPTIDE THERAPY

Patient Name:

Date of Birth:

As a patient of Dr. Jodi Berg's Integrative Family Health Clinic, I have requested peptide therapy which is used to try and prevent, reduce or control the dysfunction associated with aging process, through hormonal, balancing, control of oxidative stress, stimulating the body's own innate repair systems, and other clinically significant therapeutic agents. 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).

Understanding this, I hereby acknowledge and consent to the following:

Initial beside each statement that you have read, understand, and agree with.

_____ 1. This is my consent to Dr. Jodi Berg's Integrative Family Health Clinic, and Dr. Jodi Berg to begin my treatment for Peptide Therapy. I understand that it is my responsibility to have an annual physical examination, annual gynecological exam/breast exam/mammogram or equivalent (form male, i.e. prostate exam), including any suggested laboratory tests to ensure that I have no disease(s) which might make peptide therapy inappropriate for my condition.

_____ 2. I understand that this is a strictly voluntary procedure and no treatment is necessary or required.

_____ 3. I understand that the use of peptides is not necessarily approved for my medical conditions and that my clinical provider is providing this, following the principles of practice of medicine and the laws regulating compounding pharmacies, as a complement to my current treatments (if any)

_____ 4. I understand the possible risks associated with this treatment, as with any other drug, peptide therapies can have side effects, including but not limited to: nausea, vomiting, fever allergies (including life-threatening allergies), For injectable peptides, I understand that adverse reactions/ side effects are including but not limited to: transient high blood sugar, injection site redness, flushing, development of antibodies, water retention, pain, rash, bleeding

_____ 5. I understand that peptide dosage may be adjusted depending on side effects or a lack of response in body systems.

_____ 6. I understand that my treatment will be recommended and my clinical provider will monitor my treatment in an effort to manage any side effects, but it cannot be guaranteed that I will not experience any side effects or adverse reactions.

_____ 7. I understand that my healthcare provider cannot guarantee any health benefits or that there will be no harm from the use of peptide therapy. The potential health risks and benefits of using peptide therapy have been explained to me to my satisfaction.

_____ 8. I understand that, as with any health treatment, there is no guarantee I will receive the result I like. I understand that the procedure requires multiple sequential treatments for some time to see full benefits

_____ 9. I understand that alternatives to peptide therapy are: do nothing, standard medication use, surgery or other therapeutic intervention, or seeing another provider who believes in other therapies.

_____ 10. I understand that peptide therapy is being used as part of an integrative treatment approach.

_____ 11. I understand and certify that peptide therapy is **NOT** covered by my insurance and I am willing to cover the cost for the peptide therapy including but not limited to: consultation, peptides, any peptide refills, etc.

_____ 12. I understand that if any concerns or side effects occur, I will promptly notify Dr. Jodi Berg and the clinic staff. I also understand that Dr. Jodi Berg's Integrative Family Health Clinic is not responsible for any manufacturing issues related to these peptides, such as sterility or potency, which are the sole responsibility of the compounding pharmacy preparing them.

_____ 13. I understand and agree that peptide therapy may require laboratory monitoring or examinations at least every **three** months, at additional cost(s), as ordered by Dr. Jodi Berg, in order to continue prescribing peptides.

_____ 14. I understand that the use of this treatment does not preclude me from using other treatments as well, though I certify that I should inform any other medical practitioners I am seeing about the various treatments I am using

_____ 15. I understand that I would need to make a follow up appointment for reassessment in 1 week or as directed by the physician. I understand that effects will start to be apparent within several months after treatment.

_____ 16. I agree to the **MANDATORY** education and information following the start of my peptide to discuss the following: Proper injection techniques (for injectable peptides), medication refills and supplies, follow-up appointment information, etc.

_____ 17. I understand that if I want to discontinue treatment for any reason, I agree to schedule an appointment to discuss therapy response and any potential effect of discontinuing peptide therapy with Dr. Jodi Berg.

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 taken any medications that 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 informed consent, my consent and authorization for this procedure is strictly voluntary, discussed the issues noted above, and had opportunities to ask questions and agree freely and voluntarily accept all terms above.

I hereby grant authority to Dr. Jodi Berg's Integrative Family Health Clinic and Dr. Jodi Berg to perform peptide therapy and/or administer any related treatment as may be deemed necessary or advisable in diagnosis and treatment of my condition. I certify I am a competent adult of at least 18 years of age. This consent shall be binding upon my spouse, relatives, legal representative, heirs, administrators, power of attorney, successors and assigns.

Patient Name (print)

Patient Signature

Date

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

Medical Practitioner Name (print)

Medical Practitioner Signature

Date

Please contact our office on 425-258-2325 with any questions or concerns. If you have an emergency or urgent pressing clinical issues, call Dr, Jodi Berg at ***206-707-4640****. If immediate care is urgent, call Dr. Jodi, proceed to the nearest emergency room, or call 911*

Please note that After Hours Communication/Text Message to Dr. Jodi will incur additional charges