Peptide Therapy Treatment Consent

I have requested peptide therapy to help prevent and manage the effects of aging. This treatment works by supporting my body's natural hormone balance, reducing oxidative stress, and stimulating innate repair systems. Peptide therapy uses amino acid chains that mimic those naturally produced by the body. To achieve optimal results, multiple sequential treatments are required over a period of time.

I understand that it is my responsibility to have an annual gynecological exam/breast exam/mammogram or equivalent (for males, 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. As with any other drug, peptide therapies can have side effects, including but not limited to: nausea/vomiting, fever, injection site reactions (pain, rash, bleeding), allergies, including life threatening allergies, additional side effects not listed may also occur.

I affirm that I do not have, nor have ever had or been diagnosed with, any cancer including breast, ovarian, endometrial (uterine), or prostate cancer or medical condition that would be contraindicated with peptide therapy. I also understand that peptide therapy may require laboratory monitoring at additional cost as prescribed by my physician or healthcare provider.

Many of these hormones are used "off-label", which means they are not FDA approved. I understand that a provider is not required to use the medication as the labeling suggests. This is called off label prescribing and is specifically provided for by the FDA. These hormones are made by a compounding pharmacy. Off-label refers to use of, relating to or being an approved drug legally prescribed for a purpose for which it has not been specifically approved. I understand that the use of this peptides is not necessarily approved for my medical conditions and that my providers are providing this, following the principles of the practice of medicine and the laws regulating compounding pharmacies, as a complement to my current treatments.

CONSENT

I understand that my consent and authorization for this procedure is strictly voluntary. By signing this informed consent form, I hereby grant authority to medical providers at Meraki Renewal Clinic to perform peptide therapy and/or administer any related treatment as may be deemed necessary or advisable in the diagnosis and treatment of my condition. The nature and purpose of this procedure and the complications and side effects have been fully explained to me. I agree to adhere to all safety precautions and instructions after the treatment. I understand that the providers at Meraki Renewal Clinic can not guarantee any results or that there will be no harm. The potential health risks and benefits of using peptide therapy have been explained to me to my satisfaction. I understand that no refunds will be given for treatments received regardless of

results. I certify that if I have any changes occur in my medical history I will notify Meraki Renewal Clinic immediately.

I hereby voluntarily consent to undergo peptide therapy and that I hereby relieve Dr. Dao and NP Thanh Nguyen of any legal responsibility regarding side effects or complications that may occur due to receiving peptide therapies. I also understand that Dr. Dao and NP Thanh Nguyen are not responsible for any manufacturing issues related to these peptides, such as sterility and potency, which are the sole responsibility of the compounding pharmacy preparing them. I certify that I understand all the above information and that I have no questions about this.

Patient Name (please print)

_____

Patient Signature

_____

Date

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