

Consent for the Evaluation and Treatment
for Hormone Balancing Therapy

I authorize and give my Consent to William R. Work, M.D. and such other physicians, associates, technicians, pharmacists, as well as any other healthcare personnel of Ultimate Living Medical Clinic for the evaluation and treatment of my aging process by the administration of hormones, other pharmaceutical interventional therapies and dietary supplements, and any other non-described heretofore described interventional therapeutic agents in this document. The goal and possible benefits of this therapy are to try and stop/slow and/or reverse my aging process, through hormonal balancing, control of oxidative stress, and other clinically significant therapeutic agents.

I have been fully informed, and I am satisfied with my understanding, that this treatment may be viewed by the medical community as new, controversial, and unnecessary by the Food and Drug Administration, given the present state of knowledge regarding the human aging process.

Off Label Use

I have been completely informed, and I am totally satisfied with my understanding, that the proposed treatment may involve the use of prescription medications such as hormones that have been approved by the Food and Drug Administration (FDA) for medical conditions, other than the slowing, stopping and/or reversing of the aging process.

General Risks

I understand and am completely satisfied that the general risks of this proposed treatment and therapy include, but are not limited to, bruising, soreness or pain and possible infection at the injection site and even water retention or edema.

I understand and am fully satisfied with the knowledge, that there are risks (both known and unknown) to any medical procedure, treatment and therapy, including the proposed treatment for slowing/reversing the aging process, and that it is not even possible to guarantee or give assurance of a successful result. I freely acknowledge and accept these known...and unknown general risks.

Patient Compliance – Informed Consent Agreement

I appreciate, understand and agree to follow the proposed treatment and therapy as prescribed without any deviation, including the fact that I may be responsible for injecting, taking by mouth, applying to my skin, or administering the hormone(s) or other designated therapies that may be prescribed to me possibly more than once daily, and consent to periodically have my blood drawn or urine specimens obtained for laboratory monitoring and analysis.

I also agree to take the dietary supplements, hormone preparations, and other designated therapies on the schedule that has been individually worked out for me, as prescribed specifically in detail. *I have completely and faithfully disclosed my complete*

medical history, all prescription and non-prescription medications that I am currently taking or plan to take during my treatment, as well as any other over-the-counter medications, recreational drugs or social substances, herbs, extracts, and other dietary supplements to Dr. Work and/or his associates. I agree to completely follow the recommendations regarding the continuation or discontinuation of these preparations. In the future, I will receive prior authorization in advance from Dr. Work and/or his associates, *before stopping any of the prescribed therapeutic regimens or taking any additional preparations that are not suggested or prescribed by Dr. Work and/or his associates.*

I also understand that the use of “social substances” such as tobacco, “street drugs,” and alcohol and other type of otherwise thus non-described “social substances” may affect my therapy in a significantly adverse manner or way.

Other Medical Conditions

I will now certify that I am under the care of another physician(s) for all other medical conditions. I will consult this physician(s) for any and all other medical services that I could ever require, regardless of whether it is classified as an emergency or non-emergency personal health crisis. I will also refer to the care of this “another personal physician”, as it may relate to such physician care to e.g., general recommended screenings from the American Cancer Society or the American Heart Association, or any other truly notable resource of information-- as these issues may relate to any concepts of disease prevention or acute emergency, and suggested emergent or preventative screening techniques--as these may or could relate to any possible contemplated disease process and conceivable intervention therapies.

I certify that I will immediately notify Dr. Work and/or his associates immediately of any and all possible symptoms, signs, or possible reactions to my therapy.

(Please initial if the above paragraph is relevant to you _____)

Diagnosis

I fully understand that the medical diagnosis of “deficiency and insufficiency” do not apply to my case because such diagnosis may require tests to establish much lower levels, and as such my levels could be considered normal under that standard.

Specific Risks

The following are an example of some of the possible specific risks/adverse reactions reported for hormone therapy that may be prescribed for me. Some of these risks/adverse reactions are for prescription hormones derived from the official Food and Drug Administration “FDA” labeling requirements for these drugs, for therapeutic drug levels in the blood stream. Therapeutic blood or urine levels of medications are concentrations that show a therapeutic clinical effect. Dr. Work and/or his associates will prescribe these medications at physiologic dosages designed to accomplish physiologic levels of hormones/medications/vitamins/herbs/minerals in my blood stream. Our goal is to achieve physiologic levels that are set to that of a 30-year-old person and would be within the “normal” or “average” blood concentrations of that age group. At physiologic blood levels, there are not expected to be any significant risks/adverse reactions as

long as full medical disclosure is achieved from the patient during the total time of therapy.

Your physician may prescribe the following hormones/other medications/or nutraceuticals--as an example of such only:

**Prescription And Non-Prescription Hormones and Other
Suggested Or Prescribed Therapies:**

Human Growth Hormone (HGH) - Somatotropin

A prescription hormone given by hypodermic injection. Adverse reactions at therapeutic levels include transient high blood sugar (hyperglycemia), development of antibodies to HGH, localized joint pain and water retention. This drug should not be used in patients with a known cancer. These side effects are dose-related and are usually eliminated by adjusting the dosage.

Sermorelin

A prescription hormone given by hypodermic injection. Adverse reactions at therapeutic levels include transient high blood sugar (hyperglycemia), localized joint pain and water retention. This drug should not be used in patients with a known cancer. These side effects are dose-related and are usually eliminated by adjusting the dosage.

Testosterone

A prescription hormone given by intramuscular injection, transdermal cream/gel or subcutaneously implanted pellets. Used with caution in patients who have prostate cancer. In excess doses, males may get breast enlargement, male pattern baldness, or acne. In excess doses, women may get male pattern hair and acne.

Estrogen

A prescription hormone given by transdermal cream or subcutaneously implanted pellet. When used with or without progesterone, risks/adverse reactions could include endometrial cancer and breast cancer.

Progesterone

A prescription hormone given by transdermal cream or micronized and given orally. If the dose is missed, risks/adverse reactions could include nervousness, depression, and breakthrough bleeding and other non-contemplated symptoms or signs.

Thyroid Hormone

A prescription hormone taken by mouth. Risks/adverse reactions include palpitations, sleep disturbances, excitability, and increased metabolism. Excess amounts of this drug may suppress the body's own ability to manufacture its own thyroid hormone.

Hydrocortisone/Methylprednisolone

A prescription hormone taken by mouth. Risks/adverse reactions include edema in the legs, insomnia, osteoporosis, and fat gain. Except for insomnia, the reactions noted tend to be with higher doses of the hormone and can be eliminated by adjusting the dose.

Fludrocortisone

A prescription hormone taken by mouth. Risks/adverse reactions include facial and leg swelling, dizziness, and low potassium. The reactions noted tend to be with higher doses of the hormone and can be eliminated by adjusting the dose.

Dehydroepiandrosterone - DHEA

Given by mouth and classified as a dietary supplement. In excess amounts, adverse reactions include facial hair and acne in women, and prostate enlargement in men.

Pregnenolone

Given by mouth and classified as a dietary supplement. Should not be taken by pregnant or lactating women.

Melatonin

A dietary supplement given by mouth or sublingual. The major reported adverse side effects are sleep disorders, headache, fatigue, and exaggerated depressive symptoms. Melatonin has been commonly used to alleviate jet lag.

Other Risks

It is not humanly possible to list all the possible risks and complication and the variations that may arise in any medical procedure such as hormonal balancing in the individual examples above. Each patient may react differently to treatment. Dr. Work and/or his associates is/are willing to discuss with you, at any time, any various details about any other possible risks.

Alternative Treatments

I have been completely informed via informed consent of the existing law. I am totally and completely satisfied with my understanding of the reasonable alternatives to this procedure which include:

1. Leaving the hormone levels as they are — and doing nothing.
2. Treating age - related diseases as they appear clinically.

Other Alternatives

Although you have decided upon the proposed treatment to try to stop/slow and/or reverse the aging process by hormone balancing and other techniques described herein, do not hesitate at any time to discuss the reasons for the choices of hormones--or any other preparations prescribed for you or any other alternatives possibly available. In addition, be sure to ask Dr. Work and/or his associates questions at all times that may come up concerning your treatment.

Research Study/Photographs

I further consent to the utilization of the results of my progress in any research study performed by Dr. Work and/or his associates. I understand that my name will not be used and that every effort will be made to protect my privacy. I also understand that photographs taken of me by Dr. Work and/or Ultimate Living Medical Clinic will not be used without my expressed permission. I understand that I may suspend or terminate

my treatment at any time, upon informing Dr. Work and/or Ultimate Living Medical Clinic in writing via returned mail receipt requested.

Other Questions

I am satisfied with my understanding of the nature of this procedure and treatment, and all of my entire questions to this date have been answered completely, and I fully understand the answers to these questions with all resolve.

I do now attest to understanding and reading this form and the contents and clinical meanings of such, and discussing these procedures with my physician and consent to this treatment, and hereby affix my signature to this authorization for this proposed long-term treatment. I have been given a copy of this consent form, and I understand fully any and all of the possibly represented such implications and meanings of its writing and expectations.

Patient Signature

Date

Physician

Date

Witness Signature

Date