INFORMED CONSENT FOR PEPTIDE THERAPY

I am executing this informed consent document ("informed consent") to verify and confirm my discussion with Provider regarding the risks, benefits, and alternatives to treatment through Peptide Therapy.

I understand that Peptides are small chains of amino acids that can have biological activity. They are mostly naturally occurring. Some peptides are FDA approved for the treatment of certain diseases. Other peptides used clinically are prepared by duly registered compounding pharmacies complying with state and federal laws, but these peptides are not necessarily FDA-approved. I understand that most peptides used in integrative and regenerative medicine are not FDA-approved for the condition being treated. They may be compounded by specialized pharmacies. The FDA has not evaluated their long-term safety or effectiveness. Peptides can be administered in various presentations, including but not limited to oral, intravenous, subcutaneous, intramuscular, and intranasal routes.

I understand that the use of these peptides is not necessarily approved for my medical conditions and that my physician is providing this option for off-label use, following the principles of the practice of medicine and the laws regulating compounding pharmacies, as a complement to my current treatments.

I understand that I am a participant in the decision-making process and I am free to decline services or treatments at any time, including after treatment or services have begun. I understand that I may revoke this consent at any time before or during treatment.

I agree to bring to the attention of practice's clinical staff, if, at any time, I have any lack of understanding of such risks, benefits and alternatives, and inquire of clinical staff for further explanation until I have a full understanding before giving consent to this specific treatment or procedure.

PEPTIDE THERAPY

RISKS

I understand that, as with any health treatment, Peptide Therapy is not without risk. Potential risks of this treatment include, but are not limited to:

Common / Mild

- Injection site redness, swelling, itching, or nodules
- Headache, fatigue, flushing, dizziness
- Nausea, appetite changes, mild GI upset
- Water retention or temporary weight change

Moderate

- Joint or muscle pain, carpal tunnel–like symptoms

- Mood changes, anxiety, insomnia
- Altered blood sugar levels (low or high)
- Increased hunger or blood pressure fluctuations
- Allergic reaction or rash

Rare / Serious (Reported or Theoretical)

- Severe allergic reaction or anaphylaxis
- Injection-related infection (cellulitis, abscess)
- Immune dysregulation or flare of autoimmune conditions
- Stimulation of abnormal cell growth or tumor progression (uncertain risk)

I understand that other side effects and risks not listed here may still occur.

I am aware that Drug compounding is often regarded as the process of combining, mixing, or altering ingredients to create a medication tailored to the needs of an individual patient. Compounding includes the combining of two or more drugs. Compounded drugs are not FDA-approved.

I am aware that compounded drugs are not FDA-approved. This means that FDA does not verify the safety or effectiveness of compounded drugs. Consumers and health professionals rely on the drug approval process for verification of safety, effectiveness, and quality. Compounded drugs also lack an FDA finding of manufacturing quality before such drugs are marketed.

BENEFITS

I understand the thought process behind why Provider has suggested this particular treatment. I understand that although research is limited and outcomes vary, potential benefits may include:

- Enhanced **tissue repair and recovery** (tendons, ligaments, muscles)
- **Immune support** and modulation (e.g., Thymosin α1)
- **Reduced inflammation**
- Improved **energy metabolism** and body composition
- Better **sleep, recovery, and vitality**
- Support for **healthy aging** and performance

These benefits are **not guaranteed** and may differ between individuals.

I understand that, in general, Peptide Therapy may provide benefits that include relief of presenting symptoms and improved function that may lead to prevention, improvement, or elimination of the presenting symptoms, though no particular outcome can be warrantied or guaranteed.

ALTERNATIVES

As alternatives, Provider encourages me to speak with and consider the advice of other providers, including conventional or mainstream physicians and providers. Some alternatives include:

- **Conventional medical care**: physical therapy, prescription medications, injections
- **Lifestyle optimization**: diet, exercise, sleep, stress management
- **Orthobiologic procedures**: platelet-rich plasma (PRP), prolotherapy, stem-cell–based therapy

- **Surgery** (when indicated)
- **No treatment / watchful waiting**

In addition to discussing other modes of therapy that may be used for the treatment of my condition, Provider and I have discussed, and I understand, the possibility of a referral to a specialist for my condition(s) if I have not already consulted with an appropriate specialist.

I also understand that one alternative to this treatment is to refuse this particular treatment and to seek alternative treatments with Provider or Practice, or to refuse this particular treatment without seeking alternatives with Provider, Practice, or any other providers.

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 medications which may impair your mental abilities or if you feel rushed or under pressure.

By signing below, I acknowledge and certify that I have had opportunities to ask questions and have had them answered to my satisfaction; I have read and fully understand the foregoing Informed Consent, and I have all of the knowledge I currently desire; I have discussed the issues noted above with Provider; and I agree and accept all of the terms above. I am legally competent and have sufficient knowledge to give voluntary and informed consent.

PATIENT

SIGNATURE: ______________________________

PRINT NAME: ______________________________

TITLE (if legal representative or guardian): ___________________

DATE: __________________________

I have explained this Informed Consent and answered all questions in layman's terms, 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, comprehends the information, and has consented.

PRACTICE

SIGNATURE: _______________________________

PRINT NAME: _______________________________

DATE: __________________________