Regenesis MD

INFORMED CONSENT FOR INTEGRATIVE MEDICAL TREATMENT

As a patient, I have the right to be informed about my condition and recommended care. This disclosure is to help me become better informed, so I may make the decision to give or withhold my consent as whether or not to undergo care having had the opportunity to discuss potential benefits, risks, and hazards involved.

I hereby request and voluntarily consent to examination and treatment with integrative medical care, possibly including vitamins, minerals, supplements, IV therapies, injections, HCG, Peptides, Sermorelin, detoxification treatment modalities, lab testing, nutrition recommendations, etc. for me (or for the patient named below, for whom I am legally responsible) by Regenesis MD and Bhavna Vaidya-Tank, MD and/or Lea Lott, PA-C and/or other licensed medical providers, or those working or training at the office who now or in the future may treat me while employed by, working or training with, or serving for back up for the aforementioned. I can request that students not be included in my evaluation and treatment. I can request further explanation of the procedure or treatment, other alternative procedures or methods of treatment, and information about the material risks of the procedure or treatment.

I understand that the U.S Food and Drug Administration has not fully evaluated or approved nutritional and herbal supplements, compounded IV's/injections, HCG, Peptides, Sermorelin and bioidentical hormone replacement therapies; however, they have been widely used in Europe and the U.S for years. I understand that, as with drugs, hormones, nutritional supplements, herbal, and homeopathic remedies, ozone, nutritional IV therapies and injections may exhibit some side effects in certain sensitive individuals, may interact with certain allopathic medications or lab tests, or show symptoms, due to certain pre-existing disease conditions. I do not expect the medical provider to be able to anticipate and explain all risks and complications, and I wish to rely on the medical provider to exercise judgment in recommending the dietary supplements, medications, and treatment, that the medical provider feels at the time, based on the facts then known, is in my best interest. I understand that if I do not take the supplements or treatments as recommended, I may not get the desired result or may increase chances for an adverse effect.

It is my responsibility to keep my medical provider up to date with all of the current medications and supplements that I am taking, so that he/she can make the best informed recommendations for my care.

I have the opportunity to ask questions and discuss with my provider to my satisfaction:

- my suspected diagnosis or condition
- the nature, purpose, and potential benefit of the proposed care
- the inherited risks, complications, potential hazards, or side effects of the treatment or procedure
- the probability or likelihood, of success
- reasonable available alternatives to the proposed treatment or procedure
- the possible consequences if treatment or advise is not followed and/or nothing is done

I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

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Regenesis MD

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I understand that integrative medicine, evaluation and treatment may include, but is not limited to: collecting specimens for laboratory evaluation, ordering diagnostic imaging, prescription of certain medications and nutritional supplements, IV therapy, HCG, Peptides, Sermorelin and bio-identical hormone replacement therapy, injections, counseling, dietary therapies, PRP or other alternative remedies.

I understand that the medical providers at Regenesis MD have been trained in a diverse range of diagnostic and treatment options. I understand that Regenesis MD is highly specialized and based upon evidence-based medicine, including functional medicine and holistic principles. As such, they may recommend different tests; may interpret standard tests differently; may propose different treatments or may administer standard treatments differently than most conventional physicians as many perspectives exist in medicine and in some cases, there may be a disagreement among qualified medical experts. Care rendered may therefore be seen by some as outside standard of care or medically unnecessary. Diagnosis and treatment may include some services that are considered non- traditional, nonconventional or alternative medicine. These services may not be recognized as standard medical practices and may be considered by insurance companies to be experimental or investigational. Along with training, the rationale for these differences is based on clinical experience and ongoing continuing education in evidence based functional and integrative medicine.

I fully release, waive discharges and covenants not to sue Regenesis MD, agents, employees and designees from any and all losses, causes of action, claims, damages and liability that I, my spouse, child(ren), guests, legally authorized representative, assigns, successors and representatives may have that relates to, arises out of or is anyway connected to my use of the facility or my participation in facility activities. I agree to defend indemnify and hold harmless Regenesis MD, agents, employees or designees from and against any and all claims of any nature including cost, expenses, and fees arising out of or resulting from my actions during the facility's activities or events. I consent to receive emergency medical treatment which may be deemed advisable in the event of injury, accident or illness while at Regenesis MD or while participating in the facility activities.

In case of acute care or serious illness, please call 911 or go to the nearest ER center

By signing this form, I acknowledge I have carefully read, or have had read to me, and understand the above consent. I give my permission and consent to care and authorize medical treatment by Regenesis MD and their staff, and I am fully aware of what I am signing. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment and I may ask my physician for a more detailed explanation.

_____ _____

PRINT PATIENT NAME DOB

_____ _____

SIGNATURE OF PATIENT (OR GUARDIAN) Date