BHRT & Integrative Wellness, LLC
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Agreement for Medical Services & Consent to Treat

_____(PATIENT) and BHRT & Integrative Wellness, LLC, (PROVIDER) hereby enter into this agreement for provision of medical services specified here in ("Services"). Wherefore, in exchange for consideration, the receipt and sufficiency of which the parties hereby acknowledgment the PATIENT and NURSE PRACTITIONER agrees as follows.

I, _____, _____
(Name) (City & State)

The Services to be provided to the PATIENT include the following: suggestions for nutrition and nutritional supplements that may include plant, vitamin, mineral, and animal materials; referral for intravenous therapy when deemed necessary; diagnostic testing; pap exams; venipuncture; general physical exams; and/or hormone balancing replacement therapy to correct deficiencies. PATIENT, hereby by gives consent to evaluation and treatment with the above modalities. PATIENT makes this decision voluntarily and freely.

All female patients must notify the PROVIDER, if they are pregnant or suspect pregnancy. Some of the therapies used could present a risk to a pregnancy.

PROVIDER, and its nurse practitioner, are responsible for the evaluation and prescribing of hormone replacement therapy and laboratory testing to monitor the administration of hormone replacement. The initial laboratory testing and initial consultation will be billed separately to, PATIENT. In addition, the pharmacy, will bill the PATIENT directly for medications prescribed through the nurse practitioner.

PATIENT acknowledges and agrees that this agreement has been entered into before the PROVIDER and/or nurse practitioner has provided the Services specified to the PATIENT. PATIENT appreciates that there may be certain risks associated with the administration of hormone replacement therapy.

These risks are associated with imbalance of hormone such as breast tenderness and swelling, poor sleep, acne, weight changes, skin and hair changes etc. Additional potential risks include, but are not limited to, tissue injury from needle insertions, bruising or discoloration, infection at the injection site, and/or allergic reactions to plant, vitamin, mineral, or animal products.

PATIENT understands that no guarantees have been made regarding the outcome of this treatment or any Services provided hereunder. PATIENT also understands the benefits derived from nutritional and hormone replacement therapy will be reversed if therapy is discontinued.

The reasonable alternatives to this treatment have been explained to PATIENT, and they include:

1. Leaving the nutritional and hormone levels as they are.
2. Treating nutritional hormone related deficiencies as they appear.

Any questions PATIENT has regarding this form of therapy have been answered to PATIENT's satisfaction. PATIENT understands that PATIENT will be responsible for administering the hormones prescribed to PATIENT. PATIENT will conform and comply with the recommended doses and methods of administration. PATIENT also agrees to conform to the request for initial and subsequent testing as required to monitor hormone levels.

PATIENT certifies that PATIENT is under the care of another medical provider for other medical conditions. PATIENT understands that PROVIDER is a specialty practice and PATIENT will continue under the care of PATIENT's other medical provider (s) for any ongoing medical conditions as well as other medical consultations PATIENT may need.

PATIENT assumes full liability for any adverse effects that may result from the non-negligent administration of the proposed Services. PATIENT waves any claim at law or in equity for redress of any grievance or harm that PATIENT may have concerning or resulting from the Services, except as that claim pertains to negligent administration of the Services.

PATIENT further consents to the utilization of the results of any hormone testing for teaching purposes. PATIENT understands that PATIENT's name and demographic data will not be used and that every effort will be made to protect PATIENT's privacy.

PATIENT understands that PATIENT may suspend or terminate treatment, at any time, and hereby agreed to immediately notify PROVIDER and its nurse practitioner of any such suspension or termination.

PATIENT acknowledges and agrees that this agreement has not been entered into at a time when the PATIENT is facing an emergency or urgent healthcare situation.

PATIENT acknowledges that the Services provided by PROVIDER are neither covered by Medicare or are considered ancillary to those non-covered services and therefore are not reimbursable by Medicare.

PATIENT authorizes PROVIDER and its nurse practitioner to perform these Services. To attest to my consent to this treatment, here affix my signature to this authorization for treatment.

_____

Patient's Name (Print)

_____ _____

Patient's Signature **Date**

_____

Guardian/Personal Representative's Name (Print)

_____

Guardian/Personal Representative's Signature

_____ _____

Signature of Witness **Date**