CONSENT AND AUTHORISATION FOR MEDICAL CARE AND TREATMENT

CLIENT NAME: Glen Carroll

DATE OF BIRTH: 1 April 2012 **CLIENT NO:** 123456

GENERAL UNDERSTANDING:

I understand that ETERNITY MEDICINE INSTITUTE (EMI) specializes and employs diagnostic and therapeutic methods that may be known as “age management”, “complementary”, “holistic” and/or “wellness” medicine.

INFORMED CONSENT:

I have reviewed the benefits, options and opportunities of this program; as well as clearly understand and agree to the planned treatment. It is accepted, acknowledged and understood that I have had an opportunity to ask questions and to request additional information. I do consent to allowing my picture to be taken if required and placed in my patient file for identification purposes. I also consent to ancillary support staff performing diagnostic and treatment procedures on me that are prescribed or recommended by EMI physicians.

PATIENT EVALUATION:

I understand that: (1) blood tests and urine may be ordered to better assess my chemical, hormonal and allergy status; and (2) other tests may be ordered as EMI deems necessary to assess and/or monitor my medical condition.

TREATMENT:

I understand that EMI may prescribe any of the following for my medical condition(s): hormones, herbs vitamins, minerals, amino acids, fish oil, marine plasma, nutraceuticals, injections (e.g., testosterone) or other innovative approaches that EMI deems medically necessary for the treatment of my medical condition(s).

- For Bio-Identical Hormones Program:

I authorize Eternity Medicine Institute, its physicians, associates, assistants and other personnel to perform Hormonal Assessment and Treatment, and/or to do any other procedure that in their judgment may be advisable to my well-being, including such procedure as are considered medically advisable to obtain the maximum benefits with the least risks in regards to the proposed Bio-Identical Hormone Replacement program.

RISKS AND GUARANTEES:

I am aware that, because the practice of medicine is not an exact science, there are risks involved in any procedure or treatment. I am satisfied with my understanding of the specific risks of the Bio-Identical Hormone treatment as described by Eternity Medicine Institute. This includes risks of cancer or other diseases in association with the use of any medical therapies provided. Additional risks include weight loss or gain, increased muscular mass, decreased body fat, hair growth, change in hair color, hypoglycemia, disclosure of latent diabetes, transient fluid retention, carpal tunnel syndrome, transient joint pain, headaches, and death. I acknowledge that there is no guarantee or assurance that the results will be successful.

INSURANCE:

I understand that EMI is a fee-for-service operation and does not accept insurance. Thus I am responsible for all charges incurred with EMI, although I may submit a claim form to my insurance company for reimbursement.

PAYMENT:

I understand that payment is due at the end of each visit unless a preapproved payment plan has been arranged with EMI prior to treatment. Major credit cards, cheques or cash maybe used to make a payment.

NO TREATMENT:

I am satisfied with my understanding of the possible consequences, outcomes or risks if no treatment is rendered.

PARTIAL INVALIDITY:

If any term, provision or condition of this Agreement, or any application thereof should be held by a court of competent jurisdiction to be invalid, void, or unenforceable, all provisions and conditions of this agreement and all applications thereof not held invalid, void or unenforceable, shall continue in full force and effect and shall in no way be affected, impaired or invalidated thereby.

LIMITATION OF MEDICAL CARE:

I understand that the Eternity Medicine Institute is providing a specific medical program e.g. BHRT, Diet, Age Management, Erectile Dysfunction etc. and that my EMI physician is not taking responsibility for any other aspect of my ongoing medical health. My personal physician shall continue to provide all of my standard and continuous medical care. I hereby authorize the EMI physician to speak directly with my Primary Care physician when medically necessary regarding my past and present medical care and treatment.

CLIENT SIGNATURE **DATE**

PHYSICIAN SIGNATURE **DATE**