# Patient Consent Form for Peptide Therapy

## Patient Information

Patient Name: _____

Date of Birth: _____ Date: _____

## Treatment Information

I, the undersigned patient, hereby consent to receive peptide therapy as prescribed by my healthcare provider. I understand the following:

## Nature of Treatment

- Peptide therapy involves the administration of bioactive peptides for therapeutic purposes
- The specific peptide(s) prescribed: _____
- Route of administration: _____
- Expected duration of treatment: _____

## Potential Benefits

- Improved tissue healing and recovery
- Enhanced metabolic function
- Optimization of hormone levels
- Other: _____

## Potential Risks and Side Effects

- Injection site reactions (redness, swelling, pain)
- Headache, nausea, or dizziness
- Changes in blood sugar levels
- Allergic reactions (rare)
- Other peptide-specific effects as discussed with provider

## Patient Acknowledgment

I acknowledge that I have been informed of the nature, risks, benefits, and alternatives to peptide therapy. I have had the opportunity to ask questions and have received satisfactory answers. I voluntarily consent to this treatment.

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

Witness Signature: _____ Date: _____