INFORMED CONSENT FOR TREATMENT

Patient Name: _____

Medical Record Number: _____

I hereby authorize a health care provider affiliated with BodyForward to provide medical care and treatment to me for _____.

I understand that such treatment may include the administration of _____.

I understand that possible side effects of the use of _____ may include _____ _____. In some rare cases, _____ may occur.

I agree that, in the event that I suffer from one or more side effects, I will immediately contact BodyForward's providers or my primary care provider, or go to the nearest emergency room.

Before taking _____, I agree to disclose to BodyForward's providers all other medications I am using, including nonprescription medicines such as aspirin, and medicines for contraception, diabetes, appetite control, asthma or sinus problems, and all other medications.

The risks and benefits of _____ have been explained to me. I have been given the opportunity to ask questions and my questions have been answered to my satisfaction.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Name of Patient or Legal Guardian

_____

Witness

_____

Print Name