DFW Anti-Aging and Wellness Centers

Patient Authorization and Consent to Treatment

CONSENT TO TREATMENT: I give my consent to DFW Anti-Aging and Wellness Centers their physicians and/or staff to perform all examinations, tests, treatments, and other reasonable measures necessary to diagnose and treat my medical condition. In return, I expect them to offer recommendations, counsel and advice based upon their clinical expertise and experience. I understand that these recommendations, counsel, and advice are opinions and based upon the art of medicine, and will consider them as such.

FDA RECOMMENDATION: I understand that the FDA has not approved hCG use for weight loss, and, as such, am entering this program at my own risk. I have carefully considered my decision, and have chosen to participate of my own free will and of my own accord. I hold DFW Anti-Aging and Wellness Centers its physicians, employees and staff free from any and all liability concerning any aspect of this protocol.

NO WARRANTEE OR GUARANTEE: I understand that no warrantee or guarantee, either expressed or implied, has been made to me as to results or cure. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment shall be considered as valid as the original.

I understand that I am personally responsible for any and all charges I incur, and these charges are payable to DFW Anti-Aging and Wellness Centers.

My signature affirms all of the statements made above.

Name_____

Signature_____ Date _____

Witness_____Date _____