InVigorate

-MED SPA-

Dr. Armando C. Sciullo D.O. – 412.389.3189
Dr. H. Martin Wrigley M.D. – 724.992.0859

INFORMED CONSENT

I authorize and give my consent for the evaluation, treatment and/or prevention of the signs and symptoms associated with the process of aging via the appropriate diagnostic evaluation and the administration of bioidentical hormones, dietary supplements, and any other pharmaceutical/neutraceutical interventions deemed appropriate. I understand that goal and possible benefits are to attempt to slow or reverse the processes associated with aging through hormonal replacement and balancing, control and oxidative stress, and the use of other clinically significant therapeutic agents.

I have been fully informed and understand to my satisfaction that this treatment may be viewed by many in the medical community and the food and drug administration as new, experimental, controversial, and unnecessary.

I have been fully informed and understand to my satisfaction that the proposed treatments may involve the use of prescription medications such as bioidentical hormones or other agents that are approved by the FDA for certain medical conditions other than slowing and/or reversing the processes associated with aging.

I understand and am fully satisfied that there are risks (both known and unknown) to any medical treatment, therapy, or procedure including the proposed treatment for slowing/reversing the processes associated with aging, and that there is no guarantee or assurance of a successful result. I fully acknowledge and accept these risks.

I appreciate, understand, and agree to follow the proposed treatments and therapies as prescribed without deviation including the fact that I may be responsible for administering hormones or other designated therapies by injecting, taking my mouth, or applying to my skin possibly more than once a day, and consent to periodically have my blood drawn, saliva acquired, or have urine specimens obtained for laboratory analysis and monitoring.

I also agree to take/administer the hormone preparations, dietary supplements, and other designated therapies that have been prescribed for me in the appropriate manner. I have completely and honestly disclosed my complete medical history, including all prescription and non-prescription medications, nutritional/dietary supplements, and any recreational or social substances that I am currently taking or plan to take while under the therapies prescribed. I also understand the use of "social substances" such as tobacco, alcohol, and recreational or "street" drugs may affect my therapy in a significantly adverse manner.

I hereby certify that I am under the care of another physician(s) for any or all medical conditions. I will consult with this physician(s) for any and all medical services that I require, regardless of whether it is classified as an emergency or non-emergency. I also agree to seek care from this physician as it may relate to recommended screenings American Cancer Society, American Heart Association, or any other truly notable resources of information as these issues may relate to concepts of disease prevention or acute emergency, and suggested emergent or preventative screening techniques, as these may or could relate to any possible contemplated disease processes or conceivable interventional therapies.

I understand that each human being is unique and may react differently to medical treatments. I have been fully informed of and understand to my satisfaction the known risks and/or potential side effects of the therapies prescribed for me. I also have been informed of the reasonable alternatives to these therapies/procedures including, but not limited to, leaving the hormone levels as they currently are and treating age related diseases as they clinically appear.

I have been fully informed of and understand to my satisfaction the proposed therapies and/or procedures, the benefits thereof, and any possible risks or side effects, and the anticipated outcome. I have had the opportunity to ask all questions that I may have in this regard and fully understand the answers that I have received.

By affixing my signature to this form, I attest to reading and understanding fully all of the possible represented implications and meanings of its writings and expectations, and consent to the proposed long-term treatment.

Patient Signature: _____ *Date:* _____

Physician Signature: _____ *Date:* _____

Witness Signature: _____ *Date:* _____