Therapy Management Agreement

Date of Birth: __________

This agreement between ____________________________ and Elite Wellness & Anti-Aging establishes guidelines and conditions required for the use of hormone replacement therapy (“HRT”) involving DEA “controlled” or “scheduled” medications. Elite Wellness & Anti-Aging and patient agree that these guidelines and conditions are an essential factor in maintaining a successful patient / practitioner relationship. Adverse side effects and/or physical/psychological dependence may develop after use of these medications and therefore, these agents are prescribed with caution.

The patient agrees and accepts to the following conditions:
I understand that the medications I am receiving or will receive are prescribed for me based on diagnoses derived from my submitted medical history, the results of lab work and a physical examination. The medications are to be used exclusively for treatment of hormonal deficiencies and related medical conditions in accordance with applicable state and federal laws.

I understand and agree that no medical treatment or medication provided to me by Elite Wellness & Anti-Aging will be used for the purpose of bodybuilding, performance enhancement or physical appearance.

I certify that the answers I provide to the health questions regarding my health history to Elite Wellness & Anti-Aging, affiliated practitioners or laboratories are accurate and correct to the best of my knowledge.

I will not attempt to obtain HRT medications from any other health care practitioner without disclosing my current medical usage of HRT or other medications. I understand that it may be against the law to do so.

I have discussed and understand the risks and benefits associated with HRT. I will immediately report any adverse side effects related to the use of my HRT to Elite Wellness & Anti-Aging and discontinue use until advised to resume usage by Elite Wellness & Anti-Aging. I voluntarily assume any and all risks which may be associated with HRT.

Elite Wellness & Anti-Aging has the right to dismiss me as a patient at any time if I do not abide by the conditions set forth in this agreement. I understand that representatives of Elite Wellness & Anti-Aging are available for questions and/or concerns during normal business hours throughout the course of my treatment.

Patient/Guardian Signature: ______________________________ Date: ______________

Relationship if not the patient: ______________________________