

Longevity Medicine Therapy Agreement

Required information on Longevity Medicine Therapy, provided
by (Physician) _____

to (Patient) _____

Introduction

The purpose of Longevity Medicine Therapy is to improve your health and extend the number of your healthy years as much as possible. This type of therapy leads to an overall improvement, both internally and externally, since it aims at correcting those specific features of your body that promote the improvement of health and slowing of the aging process.

This is a special therapy carried out with the purpose to improve your health at the highest level, but your satisfaction with the outcome depends upon how fully you inform your physician about the specifics of your body. After a conversation with you and an appropriate examination, I will do my best to explain clearly to you my opinion and how to implement it. Longevity Medicine Therapy involves some effort on your part. I will try to define it clearly for you and answer any questions that may arise.

The final decision on carrying out therapy is up to you and I urge you to consider it carefully and thoughtfully.

Initial Consultation

During your visit we will discuss your medical condition, family history, previous experience with Longevity Medicine Therapy (if any), allergic reactions and chronic diseases, if any. We will consider in detail all the problems you would like to address and objectives that can be achieved. After an examination and detailed survey, we will focus on your requirements and how, in my opinion, the therapy will fulfill them. I in turn, will answer any questions that you may have.

Conclusion

Longevity Medicine Therapy can be a significant moment both for you and your physician. In order to achieve the desired results during the therapy there must be a complete understanding and awareness of both parties with respect to the wishes of the patient and treatment determined in accordance with the individual features of your body.

I have read and understood this information about Longevity Medicine Therapy, I had the opportunity to ask all questions, and to discuss and consider the content thereof.

Signature of Patient /Other Responsible Person

Date

AMERICAN LONGEVITY INSTITUTE

Witness

/

Date