LINAE HEALTHSPAN INSTITUTE, INC.
227 North El Camino Real
Suite 203
Encinitas, CA 92024
(760) 632-0100

CONSENT TO TREATMENT

I, _____, of _____,
(Name) (City and State)
hereby give my consent to evaluation and treatment with the objective of slowing and/or reversing the aging process by the administration of antioxidants and hormone replacement therapy. I understand that these procedures will involve the administration of antioxidants and hormones which may or may not include human growth hormone. If human growth hormone (HGH) is clinically indicated and prescribed I understand that HGH administration may require one or two subcutaneous injections per day. I make this decision voluntarily and freely.

In regards to HGH therapy, I appreciate that there are certain risks associated with this procedure. These risks include water retention which may result in leg swelling and elevated blood pressure which may be reversed with dose adjustment, mild increase in fasting blood sugar initially and bruises at the injection site occasionally. I may also develop infection at the injection site with improper techniques. I freely accept these risks.

I also understand there are possible benefits associated with HGH administration, which were listed in the literature that I received from Linae Healthspan Institute, Inc. I understand that no guarantee has been made to me regarding the outcome of this treatment. I also understand that the benefits derived from antioxidant & hormonal therapy, including human growth hormone, will be reversed if the therapy is discontinued.

I also understand that therapy may include "off-label" use of FDA-approved drugs such as hydergine and deprenyl. (Off-label use means use of FDA-approved medications for additional indications. As much as eighty per cent (80%) of all prescriptions are for off label uses of approved drugs).

The reasonable alternatives to these procedures have been explained to me and they include:

1. Leaving the hormone levels as they are
2. Treating age-related diseases as they appear

Any questions I have had regarding this treatment have been answered to my satisfaction. I understand that I will be responsible for injecting and administering the hormones prescribed to me. I will conform and comply with the recommended dose and methods of administration. I also agree to conform to the request for initial and subsequent blood tests, as required to monitor my hormone levels.

I authorize the Linae Healthspan Institute, Inc. and their physicians to prescribe this treatment. I understand they will be assisted by other health professionals, as necessary, and agree to their participation in my care as it relates to anti-oxidant and hormone replacement therapy. I certify that I am under the care of another physician for all other medical conditions. I will consult my physician(s) for

any other medical services that I may require. I understand that Linae Healthspan Institute, Inc. is a specialized medical practice. I also understand that I will continue under the care of my other physician(s) for any on-going medical condition as well as for any medical consultations that I may need and that under no circumstances will the Linae Healthspan Institute, Inc. prepare claims for insurance companies. I understand that the treatment and medical care I receive from Linae Healthspan Institute, Inc. does not replace treatment and medical care I may be receiving from my primary care physician or other physician specialists. Linae Healthspan Institute Inc. physicians will make every effort, when appropriate, to work collaboratively with my physicians and will also be available to me anytime while I am under their care, to provide consultation, direction and guidance for my medical needs.

I assume full liability for any adverse effects that may result from the non-negligent administration of the proposed treatment. I waive any claim in law or equity for redress of any grievance that I may have concerning or resulting from the procedure, except as that claim pertains to negligent administration of the procedure.

I hereby confirm that the nature and purpose of the aforementioned treatments may be considered medically unnecessary, experimental and not currently indicated treatments. The risks involved and the possibilities of complications have been explained to me. I fully understand that the treatment to be provided may be considered experimental and unproven by scientific testing and peer-reviewed publication.

I further consent to the utilization of the results of my progress in any research study performed by the Linae Healthspan Institute, Inc. I understand that my name will not be used and that every effort will be made to protect my privacy.

I understand that I may suspend or terminate my treatment at any time, and hereby agree to immediately notify the Linae Healthspan Institute physicians of any such suspension or termination.

To attest to my consent to this treatment, I hereby affix my signature to this authorization for treatment.

_____ _____

Signature of Patient Date

_____

Signature of Witness