Peptide Therapy Consent Form

Patient Name: _____

Date of Birth: _____

Date: _____

INTRODUCTION

Peptide therapy is an innovative treatment approach using specific chains of amino acids (peptides) to help regulate and optimize various physiological functions. This therapy may be used to support energy, improve recovery, enhance fat loss, boost cognitive performance, regulate hormones, and more.

PURPOSE

The purpose of peptide therapy is to supplement or stimulate the body's natural peptides and promote better cellular communication and function. Based on your medical history, lab results, and current symptoms, you have been recommended to start peptide therapy under medical supervision.

TREATMENT OVERVIEW

Some commonly used peptides may include:
- BPC-157
- CJC-1295 / Ipamorelin
- Thymosin Alpha-1
- TB-500
- Semax / Selank
- MOTS-c
- PT-141
- Sermorelin
- Others as deemed appropriate

The choice of peptide(s) will be based on your health status and the provider's clinical judgment.

POTENTIAL BENEFITS

- Improved immune function
- Enhanced healing and recovery
- Increased fat metabolism
- Improved sleep and cognitive function
- Hormone regulation
- Better physical performance and endurance

POTENTIAL RISKS & SIDE EFFECTS

As with any therapy, there are risks. Reported side effects may include but are not limited to:

- Redness, irritation, or pain at injection site
- Headaches, nausea, or dizziness
- Water retention
- Fatigue or changes in mood
- Changes in blood pressure or blood sugar
- Allergic reaction

Though uncommon, serious adverse reactions can occur. You are encouraged to report any symptoms or side effects immediately.

CONTRAINDICATIONS

Peptide therapy is NOT recommended for individuals with:

- Active cancer or history of hormone-sensitive cancer
- Pregnancy or breastfeeding
- Known allergies to components of the peptide formulation
- Uncontrolled chronic medical conditions without clearance

CONSENT & ACKNOWLEDGMENT

I understand that:

- Peptide therapy is considered investigational and not FDA-approved for all conditions it may be used for.
- I have had the opportunity to ask questions and all questions were answered to my satisfaction.
- I am aware that no guarantees or promises have been made to me regarding outcomes.
- I agree to notify MedfitAmerica if I experience any side effects or complications.
- I may stop therapy at any time and understand that continued medical monitoring is essential.

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____