THRIVE MD LLC

Please Print

Intake Questionnaire

Date:	Referred by:		
Name:			
Home Address:	City:	State:	ZIP:
E-Mail Address:			
Home Phone:	Cell:	Business:	
Sex:	Age:	Birth Date:	
Height:	Weight:	Desired Weight:	
Marital Status:	Number of children & ages:		
Social History	Occupation:	Employer:	
Do you smoke:	How much:	Quit:	
Alcohol consumption per week & type:			
Surgical History	Please list all surgeries:		
Medical History	Please list any prior diagnosis:		
Primary reason you came for evaluation			
Allergies to Medications			
Allergies to Food			
Allergies: Environment:			

Females: Gynecological History

How many times have you been pregnant? _____

Date of last Pap smear: _____

Have you had an abnormal Pap smear? ☐ Yes ☐No

Diagnosis: _____

Follow up: _____

Have you ever had a sexual transmitted disease? ☐ Yes ☐No

Diagnosis: _____

Date of Last Mammogram: _____

Results: _____

Have you ever had a breast biopsy? ☐ Yes ☐No

Biopsy Result: _____

Date of Last Menstrual Cycle_____ Irregular / Regular

Supplements & Vitamins	Dose	Frequency	Reason Why
Medications (prescriptions)	Dose	Frequency	Reason why

Family Medical History			
Cancer: (what type & who)			
Hypertension	Heart Disease	Osteoporosis	
Diabetes	Stroke	Other	
Antibiotic History: Have you ever taken repeated courses of antibiotics as a child for ear, throat, or respiratory infections, as a teen for acne, or as an adult for any significant infections? If so, offer brief detail.			
Exercise: Do you exercise regularly? If not, briefly state what is limiting you from doing so.			

Nutritional Assessment
What are your nutritional goals or desires?
Are you happy with your present weight? Wish to gain or lose weight?
Food dislikes: please list foods that you do not like to eat.
Do you suspect you have any food sensitivities or allergies?
Do you experience signs or symptoms of low blood sugar? (drop in energy, fuzzy headed, shaky, need frequent meals)
If one serving of vegetable is represented as ½ cup of cooked vegetable or 1 cup of raw vegetable, how many servings of vegetable do you eat daily on average?
How many servings of fish do you eat on a weekly average? Name the two most common types of fish that you eat.
How many fruit servings do you eat daily?
How much water, just plain water (not juice, pop, tea, or other liquid) do you drink on a daily basis? Express this in ounces if possible.
How often do you eat out at restaurants?
What is your typical day's food and beverage intake? List food and beverage serving size.
Breakfast:

Lunch:
Dinner:
Snacks:
Soft drink consumption, type and amount:

Current Health Care Providers	
Name & Specialty:	
Address:	
Phone #:	FAX:
Name & Specialty:	
Address:	
Phone #:	FAX:
Name & Specialty:	
Address:	
Phone #:	FAX:

Please bring a copy of the most ***recent*** lab results or procedural report (***done in the past year***). Bring any ***recent*** medical records that you feel may impact your care with us.

Score: 0 = Never 1 = Rare 2 = Occasional 3 = Most of the time 4 = Always Or if the question relates to "intensity" use this same 0 – 4 scale as the following: 0 = None 1 = Mild 2 = Moderate 3 = Moderately severe 4 = Severe					
GASTROINTESTINAL SYSTEM					
I have gas, bloating, or general discomfort after eating.	0	1	2	3	4
I have a general, hard to describe, discomfort in the abdomen	0	1	2	3	4
I experience heartburn, acid reflux, or take acid blocker medication.	0	1	2	3	4
I have constipation defined as less than one soft bowel movement daily.	0	1	2	3	4
I have watery stool more often than twice a year.	0	1	2	3	4
I alternate between diarrhea and constipation	0	1	2	3	4
I experience seasonal allergies, or ear, nose and throat problems.	0	1	2	3	4
I have recurrent sinus fullness or sinus infections	0	1	2	3	4
I have recurrent athlete's foot, fungal toenails, or other unexplained skin rash	0	1	2	3	4
I have noticed a white coating or plaque on my tongue	0	1	2	3	4
I have had recurrent vaginal yeast,	0	1	2	3	4
I have a history of IBS, Crohn's, Ulcerative colitis or other inflammatory issue	0	1	2	3	4
My stool appears black or looks like tar	0	1	2	3	4
I see mucous in my stool	0	1	2	3	4
I see blood in my stool or on the toilet paper	0	1	2	3	4
I have pain on the right side of abdomen under the rib cage	0	1	2	3	4
I have bad breath or body odor	0	1	2	3	4
Use of NSAID medication such as Advil, Ibuprofen, Aleve, Naprosyn, etc.	0	1	2	3	4
IMMUNE & ALLERGY					
I experience runny nose, congestion or drainage in throat	0	1	2	3	4

Sinus fullness or infection	0	1	2	3	4
Frequent ear and or throat infections	0	1	2	3	4
Chronic swollen lymph glands	0	1	2	3	4
Loss of smell or loss of taste	0	1	2	3	4
Catch colds and flu easily and slow to recover	0	1	2	3	4
I have bumpy skin on the back of my arms	0	1	2	3	4
Wheezing or chronic lung congestion	0	1	2	3	4
Skin rashes	0	1	2	3	4
Certain foods make me sick or nauseated, depressed or jittery	0	1	2	3	4

Score: 0 = Never 1 = Rare 2 = Occasional 3 = Most of the time 4 = Always

Or if the question relates to "intensity" use this same 0 – 4 scale as the following:
0 = None 1 = Mild 2 = Moderate 3 = Moderately severe 4 = Severe

ENDOCRINE					
I experience a drop in energy or feelings of exhaustion in the early afternoon	0	1	2	3	4
I have excessive stress in my life on a daily basis	0	1	2	3	4
I feel "on edge" throughout the day, or a feeling of being overwhelmed	0	1	2	3	4
I experience strong carbohydrate or sugar cravings	0	1	2	3	4
I drink 4 or more cups of coffee daily (one cup of coffee = 6 ounces)	0	1	2	3	4
I have dark circles under my eyes	0	1	2	3	4
Poor memory or mental focus. Trouble making decisions.	0	1	2	3	4
I feel emotionally "flat". Less ability to feel joy.	0	1	2	3	4
Poor recovery from injury or illness	0	1	2	3	4
Decreased stamina or exercise tolerance	0	1	2	3	4
Feelings of apathy or depression	0	1	2	3	4
Feel dizzy upon rising from a seated or lying position	0	1	2	3	4
ENDO - Thyr					
Feel "creaky" or stiff. Especially in the morning or after sitting for a while.	0	1	2	3	4
Muscles feel achy or are sore to touch	0	1	2	3	4
Slow to start in the morning. Takes more than an hour to feel awake, normal.	0	1	2	3	4
Dizzy or nauseated in the morning.	0	1	2	3	4
Dry skin, dry hair, brittle hair, brittle fingernails, cracking nails.	0	1	2	3	4
Thinning of the lateral or outer part of the eyebrow	0	1	2	3	4
Mental fog or difficulty concentrating	0	1	2	3	4

Tend to have cold hand and cold feet	0	1	2	3	4
Depression or low mood. Emotionally feel "flat"	0	1	2	3	4
Gaining weight easily	0	1	2	3	4
ENDO - Ins					
I feel the need to eat every 2 to 3 hours or I will feel poorly and lose energy	0	1	2	3	4
Irritable if I miss a meal	0	1	2	3	4
I crave sweets and carbohydrates (bread)	0	1	2	3	4
I awaken in the middle of the night craving sweets	0	1	2	3	4
Poor memory or poor concentration	0	1	2	3	4
I feel an increased thirst	0	1	2	3	4
Wounds seem to take a long time to heal	0	1	2	3	4
I am overweight	0	1	2	3	4
I have a family history of diabetes	0	1	2	3	4
Score: 0 = Never 1 = Rare 2 = Occasional 3 = Most of the time 4 = Always Or if the question relates to "intensity" use this same 0 – 4 scale as the following: 0 = None 1 = Mild 2 = Moderate 3 = Moderately severe 4 = Severe					
CARDIOVASCULAR					
Heart has missed beats or extra beats. Heart feels irregular	0	1	2	3	4
My heart pounds heavily, or I have palpitations at times	0	1	2	3	4
Heaviness in legs or muscle cramps while walking	0	1	2	3	4
Swelling or puffiness to feet and ankles	0	1	2	3	4
Varicose veins	0	1	2	3	4
I have loss of hair on the lower leg	0	1	2	3	4
I have experienced slurred speech	0	1	2	3	4
Experience dizziness or vertigo	0	1	2	3	4
My blood pressure is/has been high	0	1	2	3	4
My cholesterol is/has been high	0	1	2	3	4
RESP					
I have a chronic cough	0	1	2	3	4
I cough up blood or phlegm	0	1	2	3	4
I experience shortness of breath	0	1	2	3	4
I experience a wheeze	0	1	2	3	4
I smoke tobacco products – cigarettes, cigars, etc.	0	1	2	3	4
I experience chronic recurrent bronchitis	0	1	2	3	4

NEURO					
Loss of feeling in hands or feet	0	1	2	3	4
Tingling sensation or lack of feeling (numb)	0	1	2	3	4
Light headedness or fainting	0	1	2	3	4
Weakness to one or more extremities	0	1	2	3	4
Loss of balance, dizziness, or vertigo	0	1	2	3	4
Poor cognition, poor memory, reduced ability to solve problems	0	1	2	3	4
Poor mental focus or concentration	0	1	2	3	4
Nervous, anxious, or easily agitated	0	1	2	3	4
I get headaches frequently or even daily	0	1	2	3	4
I have a history of shingles	0	1	2	3	4
I get recurrent cold sores to my mouth or lip area	0	1	2	3	4
Score: 0 = Never 1 = Rare 2 = Occasional 3 = Most of the time 4 = Always					
Or if the question relates to "intensity" use this same 0 – 4 scale as the following: 0 = None 1 = Mild 2 = Moderate 3 = Moderately severe 4 = Severe					
SLEEP CYCLE					
I can't fall asleep easily, I lay in bed more than 15 minutes before I can sleep	0	1	2	3	4
I sleep less than 7 hours per night.	0	1	2	3	4
My sleep is interrupted. I awaken to urinate or for no reason at all.	0	1	2	3	4
If I awaken thru the night I have trouble falling back to sleep	0	1	2	3	4
I do not feel refreshed in the morning after awakening.	0	1	2	3	4
I feel like my brain won't shut off, it's constantly busy thinking at night.	0	1	2	3	4
I have restless legs or leg cramps at night	0	1	2	3	4
Circle ONE answer- I sleep <4 hours 4 – 5 hours 5 – 6 hours 6 – 7 hours more than 7 hours					
MUSCULOSKELATAL					
Bursitis, tendonitis, or other joint pain from soft tissue	0	1	2	3	4
Joint pain or osteoarthritis – related to the bone	0	1	2	3	4
History of rheumatoid arthritis	0	1	2	3	4
Low back pain or disc disease, degenerative spine or disc problems	0	1	2	3	4
Neck or cervical pain	0	1	2	3	4
Muscle spasm or cramps	0	1	2	3	4
Bone loss – osteoporosis or osteopenia	0	1	2	3	4
FEMALE - Urogenital					
Stress incontinence – accidentally spill urine when you cough, sneeze or laugh	0	1	2	3	4
Pain or burning with urination or frequent need to urinate	0	1	2	3	4

I have a history of frequent kidney, bladder, or urinary tract infections	0	1	2	3	4
Urine appears odd – strong smell, cloudy, bloody	0	1	2	3	4
Tender breasts – either intermittently or related to menstrual cycle	0	1	2	3	4
PMS – moody or irritable around menstrual cycle	0	1	2	3	4
Headaches related to menstrual cycle	0	1	2	3	4
Recurrent vaginal yeast infections or vaginal itching	0	1	2	3	4
Low sex drive	0	1	2	3	4
Uncomfortable intercourse secondary to vaginal dryness	0	1	2	3	4
Diagnosed with uterine fibroids – benign uterine masses	0	1	2	3	4
History of an abnormal PAP smear	0	1	2	3	4
I have fibrocystic breast disease – lumps or bumps noted in breast tissue	0	1	2	3	4
I have a history of using birth control pills – short or long term	0	1	2	3	4
Hot flashes or "power surges"	0	1	2	3	4
Night sweats	0	1	2	3	4
I had difficulty getting pregnant or required fertility treatments	0	1	2	3	4
I have a history of genital herpes	0	1	2	3	4
Score: 0 = Never 1 = Rare 2 = Occasional 3 = Most of the time 4 = Always					
Or if the question relates to "intensity" use this same 0 – 4 scale as the following: 0 = None 1 = Mild 2 = Moderate 3 = Moderately severe 4 = Severe					
MALE - Urogenital					
I have a history if swollen prostate or benign prostatic hypertrophy	0	1	2	3	4
History of prostate infection – prostatitis	0	1	2	3	4
Slow in initiating urinary stream	0	1	2	3	4
Reduced flow or force of urinary stream	0	1	2	3	4
Frequent need to urinate	0	1	2	3	4
Awaken in the night to urinate	0	1	2	3	4
Erectile dysfunction – incomplete erections	0	1	2	3	4
Loss of sex drive	0	1	2	3	4
I have a history of herpes	0	1	2	3	4
Urinary tract infections	0	1	2	3	4

CONSENT FOR TREATMENT: I, the patient named above, do request and consent to have Thrive MD, LLC and their employees, evaluate and treat the above patient for medical complaint and illnesses. This includes, but is not limited to, taking of medical information, evaluation by physical examination, obtaining of bodily fluids for laboratory testing, the administration of medications for treatment, and any other treatment or evaluation that may be necessary. If, at any time, I do not wish to have these services rendered, I may state so and they will not be provided, but an AMA form may need to be signed by the patient. All of my information will remain confidential. I acknowledge that I have been offered a copy of Thrive MD, LLC Notice of Privacy Practices.

CONSENT FOR TEST INFORMATION: □ by checking this box I agree to be contacted by phone and voicemail may be left, and/or by email by our staff regarding your medical treatment and information.
Phone # ____ - ____ - _____

Email: _____

By signing below, I hereby certify that to the best of my knowledge all information I have furnished on this form is complete, true and accurate, I also understand this agreement between Thrive MD, LLC.

Patient Name _____

Signature _____

Date ____/____/___

THRIVE MD

Please check any of the following symptoms you are experiencing.

Male symptoms of low testosterone:

Difficulty concentrating	☐Yes ☐No
Moodiness	☐Yes ☐No
Depression	☐Yes ☐No
Weight gain	☐Yes ☐No
Decreasing sex drive	☐Yes ☐No
Increasing fatigue	☐Yes ☐No
Decreasing energy	☐Yes ☐No
Daytime sleepiness	☐Yes ☐No
Poor sleep habits	☐Yes ☐No
Erectile dysfunction	☐Yes ☐No

Female symptoms of hormone imbalance:

Hot flashes	☐Yes ☐No
Night sweats	☐Yes ☐No
Mood swings	☐Yes ☐No
Depression	☐Yes ☐No
Weight gain	☐Yes ☐No
Trouble sleeping	☐Yes ☐No
Decreased mental clarity	☐Yes ☐No
Less interest in sex	☐Yes ☐No
Pain during intercourse	☐Yes ☐No
Vaginal dryness	☐Yes ☐No
Heavy vaginal bleeding	☐Yes ☐No
Breast tenderness	☐Yes ☐No
Acne	☐Yes ☐No
Thin and/or dry skin	☐Yes ☐No
Excessive hair on face and arms	☐Yes ☐No
Thinning hair on head	☐Yes ☐No

TESTOSTERONE MEDICATION USE AGREEMENT

This Testosterone Medication Use Agreement (the "Agreement"), made and entered as of _____ _____, 2017, by and between _____ (the "Patient"), and Thrive MD, LLC a Colorado Limited Liability Company ("Thrive MD"). The Patient hereby agrees and expressly authorizes Thrive MD to secure a medical laboratory, physician/medical doctor ("Treating Physician") and dispensing pharmacy (collectively " Medical Providers") to provide the Patient diagnostic testing, medical care and prescribed pharmaceuticals based on the completed and accurate medical history form ("Medical History Form") provided by the Patient, and any laboratory diagnostic tests obtained through Thrive MD, pursuant to and subject to the terms and conditions of this Agreement. The Patient understands that the Medical History Form becomes the property of Thrive MD and the Patient will have continuing access and the right to copy and retain all portions of the medical record, subject to applicable law.

MEDICATION USE OF TESTOSTERONE

1. **Competency.** The Patient hereby understands that testosterone, anti-estrogen, and human chorionic gonadotropin therapy for adults involves the use of medications that may be approved for a different purpose in an effort to obtain an objective of medical treatment. The Patient is a competent adult and permitted by law in the state of residence to receive the medication(s) requested for personal and therapeutic purposes. The Patient acknowledges he/she has been fully informed by appropriately trained health care personnel and understands the risks, benefits, and possible side effects of the prescription drug(s) requested.

2. **Purpose.** The Patient executes this agreement with the complete understanding and for the sole purpose of authorizing Thrive MD, at its discretion, to administer medication for the relief of body ailments, to enhance the physical condition and health of the Patient. The Patient consents to the receipt of any prescribed drug approved for medical use in the country of residence. The Patient understands that the methods of medical treatment offered or provided by Thrive MD or the Medical Providers are not accompanied by any claims, guarantees or promises.

3. **Compliance.** The Patient agrees to immediately cease any medical treatment prescribed by the Treating Physician in the event of any adverse response or side effect arising from prescribed treatment and provide immediate written notice to Thrive MD. The Patient further agrees to comply with instructions for use of any and all medications and to promptly contact a local physician for any necessary medical intervention should a complication or concern resulting from the use of a requested medication arise. The Patient acknowledges that there are risks as well as benefits to any medication, even over the counter drugs and have been fully informed of the possible effects, risks, and benefits of this medication.

4. **Assumption of Risk; Waiver of Claims.** The Patient understands and acknowledges that the practice of medicine is not an exact science and that diagnosis and treatment may involve risks of injury and acknowledges that no promises, assurances, or guarantees have been made as to the result of diagnostic testing, analysis of test results, and examination of medical history or treatment by Thrive MD or the Medical Providers. The Patient understands that the hormone blood level objective sought to result from hormone replacement therapy, as prescribed by the Treating Physician, may be the highest level of a standard reference range for any sex and age, or may be an even higher hormone blood level than normally found in a person younger than the Patient. The Patient understands that hormone replacement therapy for the purpose of elevating hormone blood levels is experimental and may not render any

Patient Initials: _____

benefits, but may result in unknown adverse results. The Patient is aware of the nature, risks, possible alternative methods of treatment, possible consequences, and possible complications involved in treatment. Accordingly, the Patient waives any and all claims against Thrive MD, its physicians, owners, members, managers, agents, and Medical Providers for the treatment provided by Thrive MD and its Medical Providers.

5. **Indemnification.** The Patient indemnifies and waives any and all claims or defenses that they may have against Thrive MD for any harm or injury suffered as a result of failure to fully disclose all relevant facts about the physical and medical condition of the Patient to Thrive MD or the Medical Providers, including, but not limited to, the information on the Medical History Form. The Patient also indemnifies Thrive MD and the Medical Provider for any and all claims and defense for injuries or illnesses sustained as a result of the failure to comply with the method of treatment and dosage schedule prescribed by the Treating Physician or any other Medical Provider.

ADDITIONAL TERMS AND CONDITIONS

6. **Expenses.** Except as otherwise expressly provided herein, all costs and expenses, including, without limitation, fees and disbursements of counsel, financial advisors and accountants, incurred in connection with this Agreement and the transactions contemplated hereby shall be paid by the party incurring such costs and expenses, whether or not the procedure shall have occurred.

7. **Headings.** The headings in this Agreement are for reference only and shall not affect the interpretation of this Agreement

8. **Amendment and Modification; Waiver.** This Agreement may only be amended, modified or supplemented by an agreement in writing signed by each party hereto. No waiver by any party of any of the provisions hereof shall be effective unless explicitly set forth in writing and signed by the party so waiving. No waiver by any party shall operate or be construed as a waiver in respect of any failure, breach or default not expressly identified by such written waiver, whether of a similar or different character, and whether occurring before or after that waiver. No failure to exercise, or delay in exercising, any right, remedy, power or privilege arising from this Agreement shall operate or be construed as a waiver thereof; nor shall any single or partial exercise of any right, remedy, power or privilege hereunder preclude any other or further exercise thereof or the exercise of any other right, remedy, power or privilege.

9. **Governing Law; Jurisdiction.** This Agreement shall be governed by and construed in accordance with the internal laws of the State of Colorado without giving effect to any choice or conflict of law provision or rule (whether of the State of Colorado or any other jurisdiction). Patient expressly agrees that the jurisdiction and venue for any medical, legal or equitable claim of any type whatsoever, or any dispute regarding pharmaceuticals, physicians, physician services, medical laboratories or any services or products provided to Patient by Thrive MD shall exclusively in the City and County of Denver, Colorado.

10. **Attorney Fees; Costs.** Patient agrees to pay all reasonable attorney's fees and court costs incurred by Thrive MD if such claim is brought in violation of the terms and conditions of this Agreement. Further, in the event Thrive MD prevails under any action brought under this Agreement by Patient or, alternatively, by Thrive MD against Patient, Patient shall pay all reasonable attorney's fees and costs incurred by Thrive MD in defending or prosecuting such claim.

Patient Initials: _____

The parties hereto have caused this Testosterone Medication Use Agreement to be executed as of the date first written above by their respective officers thereunto duly authorized.

Thrive MD:

By: _____
Print Name: _____
Title: _____

Patient:

_____
Print Name:

Patient Initials: _____

THRIVE MD

Name of Patient: _____

Patient Date of Birth: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices with the effective date of January 1, 2017

_____ _____

Signature of Patient/Patient Representative Date

_____

Relationship to Patient

Documentation of Good Faith Efforts
To obtain patient's acknowledgment that they received provider's Notice of Privacy Practices

(For use when acknowledgment cannot be obtained from the patient.)

The patient presented to the office/hospital on _____ and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- ☐ Patient refused to sign.
- ☐ Patient was unable to sign or initial because:

_____

- ☐ The patient had a medical emergency, and an attempt to obtain the Acknowledgment will be made at the next available opportunity.
- ☐ Other reason (describe below):

_____

Signature of Employee Completing Form: _____

Date Signed: _____

THRIVE MD

Authorization to Use or Disclose My Health Information

Patient name: _____ Date of birth: _____

Previous name: _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

☐ All my health information maintained by the above-named practice

☐ My health information relating to the following treatment or condition: _____

☐ My health information for the date(s): _____

You may disclose this health information to:

Name (or title) and organization _____

Address: _____ City _____ State _____ Zip _____

Reason(s) for this authorization (check all that apply):

☐ At my request

☐ Check here only when ThriveMD requests the authorization for marketing purposes

☐ Continuation of care

☐ Other (specify) _____

_____

This authorization ends: ☐ On (date) _____

☐ When the following event occurs _____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment or eligibility for benefits). However, I do have to sign an authorization form:

- To take part in a research study;

  Or
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I revoke this authorization, it would not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. The form is available from the office;

  or
- Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may be able to re disclose it. Privacy laws may no longer protect it.

_____ _____ _____

Patient or legally authorized individual signature | Date | Time

_____ _____

Printed Name if signed on behalf of the patient | Relationship (parent, legal guardian, personal representative, etc.)

Thrive MD

Patient Waiver

I fully understand that the physicians and health care clinicians at Thrive MD are integrative care practitioners that combine traditional medical treatments with nutritional and integrative medicine alternatives. The physicians and clinicians also understand the benefit of homeopathic and naturopathic philosophies and may choose to adopt these elements in my treatment plan.

I fully understand that the practitioners seek to improve my overall health and wellness and that the process or modalities used may not be in line with the "standard of care" of traditional medicine but that my practitioners here are selecting therapies that they feel to be equal or superior to the standard of care based on their past experience and/or based on the medical literature. I understand and accept that traditional medicines "standard of care" may not be optimal for my situation. Traditional drug therapies employed by traditional medical practice may or may not be employed to address my particular issues. They will be considered but ultimately a decision may be made to pursue a more beneficial, less harmful, natural approach to address my medical issues. As such, I will not hold the practitioners at Thrive MD accountable to practice "standard of care" as defined by traditional medicine. I fully expect that all staff members will operate in my best interest and work to promote my health.

If at any point I prefer to be treated with traditional drug therapy for the treatment of any health issue such as hypertension, diabetes, heart disease, or any medical condition, then I will make this desire known and the staff here will be more than happy to discuss the pros and cons of traditional versus alternative therapy and offer guidance with whichever approach I am most comfortable with. Often these approaches can be blended or combined. The goal at Thrive MD is always to serve the patient's needs in the safest fashion possible.

I fully understand the services provided by the attending consultants may not be generally accepted and/or recommended by my traditional doctors or other conventional health professionals. The attending consultants are in no way encouraging me to terminate any previous and/or current therapies that other doctors have started. I am encouraged to maintain a relationship with my primary care physician, as this office functions more as a consultant and is not available 24 hours a day for emergencies other than by the answering service. Should I desire any services not provided by Thrive MD or outside the scope of practice, and then I am encouraged to seek needed services elsewhere. The staff here will always work with me to find the services I need or be available to answer any questions my other health care providers may have about my treatment here.

If I am accompanied by and am signing for a minor or other family member who is unable to offer competent consent, I give full faith that I am legally and totally responsible.

I have read and understand this document entirely and I have been given the opportunity to receive a verbal explanation of the same from the attending consultants and they have satisfactory answered all of my questions and or doubts.

I understand and agree to the information contained here on this date: _____

Clients name: (PRINT) _____

Client / Responsible Party Signature: _____

Client Parent or Guardian Signature: _____