

Informed Consent

Please Read Carefully and acknowledge your acceptance before continuing:

I, _____ specifically authorize Dr. Wilson to perform an analysis and develop for me a suggested plan for optimal health. I warrant that all information submitted for analysis and evaluation was submitted by me and is true to the best of my knowledge.

I acknowledge that the "Time is on Your Side" Program, the Evaluation, Laboratory Bloodwork and the Physical Examination are for the diagnosis, treatment, care, alleviation, mitigation, prevention, and/or care of possible health risks. I reserve the right to use the knowledge I gain in the care of my own body in any legal manner I choose.

I recognize that the "Time is on Your Side" Program is a proactive wellness plan that has not yet been approved by the conservative factions of the medical profession or the Food and Drug Administration, although it has not been rejected.

The "Time is on Your Side" Program is based on years of combined experience with Traditional Primary Care Medicine and Anti-Aging Medicine. We promote proper diet, adequate daily exercise, hormonal balance and the early detection/prevention of disease.

I understand that I am responsible for all costs of treatment(s) provided by the program and that many may not be covered by traditional insurance plans.

Please sign X _____ to indicate that you have read and understand the instructions and that you agree with the above terms and disclaimers.

Whom may we thank for your referral?
