CONSENT AND WAIVER FORM

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the treatment at the offices of Elie Sader, MD, PLLC (the "Practice'). This document serves as a supplement to the discussion you have with your doctor/healthcare provider. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions, ask your doctor/healthcare professional prior to signing this consent form.

I understand and agree that the initial consultation with the Practice does not establish a doctor-patient relationship, in any way, and the Practice will not prescribe any prescriptions to me until I am a patient of the Practice.

By signing this form, I agree to and understand the following:

I hereby request and consent to receive treatments by the Practice and any of its associates.

I understand that there are certain treatment procedures that are inappropriate for any individuals who are pregnant and that it is my responsibility to immediately tell the Practice if I become pregnant, so that proper precautions can be taken.

I understand that there are certain treatment procedures that are inappropriate for anyone who has a pacemaker and that it is my responsibility to immediately tell the Practice if I have or ever come to have a pacemaker, so that proper precautions can be taken.

I have provided the office with a full and accurate list of all medications that I am currently taking. I understand that it is my responsibility to immediately tell the Practice if I change or add to my current medications, so that proper precautions can be taken.

I have provided all necessary medical, mental and physical information that is known to me at the time of signing this document. I understand it is my responsibility to update the Practice accordingly, in writing, of any changes to my medical, mental and/or physical condition. Should I not provide accurate information or fail to update the Practice of any changes in writing, I agree to release Elie Sader, MD, the Practice, its predecessors, parent, subsidiaries and affiliates, officers, and employees of any and all liability for any and all injuries, damages or claims.

I understand that the Practice may recommend supplements during the course of my treatment. I further understand that supplements have labeling that has been approved by the makers of the medication and the Food and Drug Administration. This labeling contains information on how to take such medication or supplements. I understand it is my responsibility to follow the instructions carefully and to report to the Practice any significant medical problems that I think may be related to the treatment immediately. I also understand that the Practice may prescribe medications off label but that are well recognized in the medical community and commonly prescribed.

I further understand that while the Practice or any of its associates may make certain recommendations to me during my treatment, including the use of supplements, it is entirely my own decision whether or not to accept and follow these recommendations.

If I experience a medical emergency, I should call 911 or go immediately to my nearest emergency room for medical care, diagnosis and/or treatment.

I agree that I will not record, whether through video or audio, any appointments with the Practice at any time.

I understand that the Practice will keep all communications and records confidential unless I consent in writing to share this information with others. However, I consent to the Practice's use and disclosure of my Protected Health Information (PHI) for the purpose of providing treatment to me, for the purposes relating to the payment of

services rendered to me and for the office's general healthcare operations purposes. PHI relates to any information created or received by the office that relates to my past, present or future physical and mental health or condition, that either identifies me or provides a reasonable basis to believe the information can be used to identify me.

I acknowledge that I have read and understand the HIPAA privacy agreement provided to me by the Practice.

While there have been no warranties, assurances, or guarantees made to me, I consent and freely agree to receive treatment from Elie Sader, MD, PLLC. I have read and understood the information provided in this Consent Form, as well as all materials provided to me. I have asked any and all questions that I may have about the treatment, and these questions have been answered to my full satisfaction.

I further agree to hold Elie Sader, MD, the Practice, the office and any associates or staff of the Practice harmless from any and all liabilities and claims, which may arise as a result of my participation in the treatment. I will not hold them responsible for the consequences of any decisions I may make, or any actions I may or may not take, following any recommendation made by them.

I understand that the Practice utilizes an email system that is HIPAA compliant. I further understand that my personal email may not be HIPAA compliant and there is a potential risk of using this form of communication, including the potential access of unauthorized persons due to the technology and breach of said technology through no fault of the Practice or me. By signing below, I agree to communicate with the Practice through email. If I choose, I can always opt out of this method by informing the Practice, in writing, and clearly indicating my preferred method of communication. The Practice will respond to all my emails within a reasonable period of time, but not to exceed 72 business hours. I understand that to best protect my information, any email I sent should not contain any PHI or personal information about me.

I represent that I am of sound mind and am legally competent to understand and complete this agreement. I hereby execute this consent form without coercion.

_____ _____

Patient's Signature Date

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Patient's Printed Name