Medical Treatment Agreement

This agreement between _____ (Patient) and Ultimate Prime, LLC.

LLC (Ultimate Prime) establishes guidelines and conditions required for the use of hormone replacement therapy (HRT) involving DEA "controlled" or "scheduled" medications. Ultimate Prime and Patient agree that these guidelines and conditions are an essential factor in maintaining a successful patient/physician relationship. Adverse side effects and/or physical/psychological dependence may develop after repeated use of these medications and therefore, these agents are prescribed with caution.

THE PATIENT ACCEPTS AND AGREES TO THE FOLLOWING CONDITIONS:

01. I understand that the medical treatment offered by Ultimate Prime and their Physician(s) is not accompanied by any claims, guarantees, promises or warranties.

02. I understand that the medications I have purchased are prescribed for me based on diagnoses derived from my submitted medical history, blood work, and physical examination. They are to be used exclusively for treatment of these diagnoses.

03. I will not attempt to obtain "scheduled" hormone replacement therapy medications illegally or from any other healthcare practitioner without disclosing my current medication usage. I understand that it’s against the law to do so.

04. I will immediately report any adverse side effects related to the use of my medication to Ultimate Prime and discontinue use until advised to resume usage by Ultimate Prime.

05. I understand that the Ultimate Prime Physician (MD) and/or Licensed Physician's Assistant (PA-C) are available for questions and/or concerns during normal business hours throughout the course of my treatment.

06. I will safeguard my medications from loss or theft and will be responsible for their safekeeping.

07. I agree that these medications are for my personal use only and no other purpose and I will not share, sell, or trade my Medications.

08. I agree that I will use my medications at the prescribed rate and dosage and will keep the medication in its respective
labeled container.

09. I agree and understand that federal regulations prohibit the return of prescribed medications.

10. I agree to contact Ultimate Prime 4-6 weeks into the start of my therapy (and every 3 months thereafter) to arrange for any follow-up blood testing and/or an office visit/consultation as required by the Ultimate Prime physician.

11. I agree and understand that completing the required forms, lab work and exams doesn't automatically qualify me for treatment. Only the prescribing physician can determine if I qualify.

12. I agree that the Ultimate Prime patient/physician relationship is not intended to replace the existing relationship with my current primary care provider (PCP) and my Ultimate Prime treatment will be in conjunction with the care provided by my current PCP.

By checking this box, I acknowledge and understand that charges will appear on my Credit Card Statement as “Ultimate Prime LLC”.

Patient’s Signature

Date

Most patients are very anxious to hear the results of their lab tests or other determinations made by our medical staff regarding their treatment. Due to a physician’s schedule, communication of the results, especially if they are within normal ranges, is sometimes delayed. Although all Ultimate Prime personnel, both professionals and non professionals, are part of the Health Care Operations of the practice, and therefore do not require a specific HIPAA consent form, Ultimate Prime takes the confidentiality of your personal health information very seriously and does not permit its personnel who are not directly involved in your medical assessments and treatment with access to your medical records without your written consent. By signing this form, you will give permission to allow your personal Ultimate Prime Client Liaison, or other administrative staff member, to communicate to you via phone, email, text message, in writing, or in person, protected health information pertaining to your medical care.This consent form does not allow Ultimate Prime to share your health information with any third-party for any reason. It simply authorizes our administrative staff to convey information from our medical staff to you, at your request. Understand that administrative staff cannot answer specific questions about the meaning of test results or treatment modalities, and if you have such questions after receiving the results, your client liaison, or other administrative staff member, will have a physician or other qualified health professional contact you to answer your questions. Authorization for Ultimate Prime to Release Health Information to Myself

I, _____, hereby give my consent for Ultimate Prime LLC. (Ultimate Prime), and their non-medical professional and administrative staff to disclose my protected health information, Ultimate Prime Client Liaison, or other administrative staff, may communicate to me by phone, email, text message, in writing, or in person, information that assists the practice in carrying out operations related to my treatment; such as, appointment reminders, billing issues, and communications related to my clinical care, including laboratory test results. I acknowledge that such liaison or staff cannot answer specific questions about the results or course of my treatment as they are

not a health professional, and any opinions and/or casual conversation they might gratuitously offer are not to be construed as medical advice, and that I can request a physician or other health professional to contact me to answer my questions.I understand that I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. I understand that this form is not required under the HIPAA privacy rule, but if I choose not to consent, or later revoke consent, Ultimate Prime may be unable to continue to provide treatment to me, but they will not do so without affording me a reasonable time, not longer than thirty days, to obtain a successor physician/practice.

Patient’s Signature Date