Echelon Integrative Health

Peptide Therapy Informed Consent Form

Patient Name: _____ Date of Birth: _____Date: _____

Purpose:

I understand that I am being prescribed peptide therapy to support and optimize physiological functions such as hormone regulation, tissue repair, immune modulation, and/or metabolic function.

Description of Treatment:

Peptide therapy may include compounds such as: BPC-157, CJC, Sermorelin, Ipamorelin, Tesamorelin, Bremelanotide, IGF, Semaglutide, MK-677.

I understand that peptides are administered by injection, oral, sublingual, or nasal routes, depending on the specific compound.

Potential Benefits:

- Improved recovery and healing
- Enhanced energy and mental clarity
- Weight management support
- Improved immune function
- Increased growth hormone levels
- Better sleep and Mood

Possible side effects may include:

- Injection site reactions (pain, redness, swelling)
- Headache, dizziness, or fatigue
- Water retention or bloating
- Nausea or upset stomach
- Hormonal Changes
- Unknown long-term risk

Consent:

I understand that peptide therapies are not FDA approved for all uses and are considered investigational/ off label in most cases.

I have read and understand the information provided. I have had the opportunity to ask questions, and all questions have been answered to my satisfaction. I consent to receive peptide therapy and assume full responsibility for any risks associated and will not hold Echelon Integrative Health, Dr. Iannotti, Chelsey Dobesh NP, or staff to any and all possible scenarios and consequences. I agree to follow the prescribed dosing schedule, report any side effects promptly, and attend follow-up visits or labs as directed.

All Peptide Injections must be Purchased prior to ordering. Allow 2 weeks for compounding. Amounts vary

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____