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# PATIENT'S INFORMED CONSENT AND AUTHORIZATION FOR MEDICAL CARE

1. I hereby agree and authorize Larry Bryan Mabry MD PLLC (abbreviated from now on as "LBM") to treat me for high serum estrogen levels and/or low endogenous testosterone production, which is expected as a consequence of anabolic/androgenic steroid use. Alternatively, I may be applying for Hormone Replacement Therapy. I understand that I am contracting with LBM for treatment of these two specific conditions only, and that any other medical problems I may experience now, or in the future, must be diagnosed and treated by my own physician.
2. I am at least 18 years of age.
3. I am a male.
4. I understand that LBM recommends I undergo regular and complete physical examinations by my own Primary Care Physician (PCP).
5. I understand that LBM may, at its discretion, accept a physical examination by my own PCP or medical specialist (or his/her agent) in lieu of a physical examination personally conducted by an LBM physician. If such is the case, I am agreeing that such a physical examination will be sufficient for the purpose of being treated by LBM, and that any errors or omissions as a result of this agreement are in no way the fault of LBM.
6. I agree it is my personal decision to use ***anabolic/androgenic steroids*** (abbreviated from now on as"AAS") (for AAS Consults)
   and that LBM does not condone their usage. LBM has not given me any advice on how to use steroids, except to help protect my health or warn me of their possible side effects. I will not ask LBM for advice on how to use anabolic steroids, or for help in designing a steroid cycle.
7. I am furnishing a Medical History Form which is accurate and complete.
8. I have detailed any current and past steroid cycle on the Medical History form.
9. I understand one or more physicians may review my Medical History Form on behalf of LBM, and may also make recommendations regarding my treatment.
10. I will not give, sell or allow anyone else to use any medications provided to me through my relationship with LBM.
11. I understand that LBM has contracted with one or more separate pharmacy distributors to provide me, delivered to the address of my choosing, one or more medications and/or syringes, if any such medications/syringes are recommended by LBM. LBM may, at its discretion, dispense medications and/or syringes.
12. I understand that LBM will provide a prescription for syringes should that be necessary in the state in which I reside, but only if I specifically request one.
13. If I am an AAS patient, I understand that LBM may advise me to undergo certain laboratory tests, and if I choose to ignore LBM's advice, it is at my own peril. If I am a HRT patient, I agree to undergo follow-up laboratory testing, and/or physical examination by my own PCP, or by an LBM physician, as the case may be, necessary to monitor my health and the effectiveness of my treatment. I understand that LBM may

discharge me as a patient, and is not responsible for the consequences of my failure to heed any physician's advice, if I fail to follow LBM's recommendations.

14. I understand that medicine is an art rather than an exact science, and that diagnosis and treatment may involve risks or injury.
15. I understand that Hormone Replacement Therapy, and the use of ancillary medications while taking steroids or undergoing HRT, may have unknown side effects which may not become evident until the future.
16. I acknowledge the particular usage of the medications provided through LBM may be considered "off-label."
17. I will take any medications provided through LBM in exactly the manner prescribed by LBM's physician(s).
18. I will rely upon a medical professional with appropriate training for any injections I may receive as part of my treatment from LBM. If I choose to inject them myself, or let anyone else inject them for me, it is at my own peril.
19. I understand that, due to Federal Law, prescription medications may not be returned.
20. I understand that delivery of medications obtained through LBM is guaranteed within the continental United States.
21. I understand that the medications which may be provided to me through LBM may, in some cases, cause side effects. If I should experience any such side effects, I will immediately cease using them, and notify LBM immediately. I will also contact my own local physician and/or, if necessary, immediately go to a local Emergency Department.
22. In exchange for review of my completed Medical History Form I agree to pay LBM's Consultation Fee. Additional charges may be added to cover the cost of any prescription medications, syringes, or Follow-Up Fees LBM deems appropriate.
23. I will not bill Medicare, Medicaid or any federal or state funded health benefit program for either the medical consultation, or medications provided by, or through, my association with LBM. I also understand LBM may provide me with a receipt, if I specifically request one, for my Consultation Fee, and any medications and/or syringes I may choose to purchase, but does not directly bill medical insurance companies.
24. I understand that by signing this agreement I am giving up the right to sue LBM, its doctors, anyone connected in any way with ATM, or the pharmacy(s) which fulfill LBM's prescriptions FOR ANY REASON WHATSOEVER, FOREVER.
25. Even though I am agreeing to never sue LBM, or anyone connected in any way to LBM, any such filing must be in Washington County, AR. I also agree then to pay ALL costs incurred by LBM as a result of that claim, regardless of any outcome, and to pay such costs immediately, on a weekly basis. Failing to do so will automatically end any claim(s) made by me, my family and/or my agent(s).
26. I understand LBM, and doctors obtained to provide medical treatment to me through LBM, have elected not to carry malpractice insurance due to the unique and unconventional nature of the medical treatment they provide.
27. I have read this contract carefully. Any questions I may have about it have been answered by LBM.
28. I understand that this constitutes the entire agreement between LBM and me.

Signed:_____Print Name:_____ Date:_____