Patient Name____ Patient DOB__________________

INFORMED CONSENT FOR HAIR RESTORATION TREATMENT WITH THYMOSIN BETA-4 & GHKCU SPRAY

I seek the medical services of Yoo Direct Health, LLC and their employees. I am executing this consent to confirm my discussion with Yoo Direct Health providers and my understanding of the risks, benefits, and alternatives for hair restoration treatment with **THYMOSIN BETA 4 AND GHKCU SPRAY**. The goal and possible benefits of this therapy are hair restoration and hair growth.

However, I understand that this treatment may be viewed by the mainstream medical community as new and controversial, and unnecessary by the Food and Drug Administration ("FDA").

Benefits and General Information

Thymosin Beta-4 is an actin sequestering protein which plays a role in regulation of actin polymerization, injury repair, and immune modulation. Thymosin Beta-4 plays a role in increasing healing by enhancing angiogenesis, cell migration, and promoting stem cell differentiation.

Benefits of GHK-Cu Spray**:** is used to treat hair loss as result of androgenic alopecia. GHK-Cu can increase hair growth, and thickness and enlarge the follicle size

Potential Risks The following are examples of some of the possible specific risks/adverse reactions reported for therapy that may be prescribed for me. Some of these risks/adverse reactions are for prescription drugs derived from the official FDA labeling requirements for these drugs. At physiological blood levels, there are not expected to be any significant risks/adverse reactions if full medical disclosure is achieved from the patient during the total time of therapy.

T R A I N I N G A C A D E M Y

Contraindications

I understand that it has been advised that I should not receive this therapy if I have the following conditions:

- Misuse of or dependency on any drug
- Currently pregnant or lactating or are planning to become pregnant in the next 12 months
- Known allergy or intolerance to **THYMOSIN BETA 4 and GHKCU SPRAY** or any of its other contents

By signing this form, I understand the possible risks associated with this treatment.

I understand that Yoo Direct Health providers will monitor my treatment in an effort to prevent any side effects but cannot guarantee that I will not experience any side effects or adverse reactions. I understand that, as with any health treatment, there is no guarantee I will obtain satisfactory results with this therapy. I understand the use of this treatment does not preclude me from using other treatments as well, though I recognize that I should inform any practitioners I am seeing about the various treatments I am using.

NOTE: DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING THIS FORM. DO NOT SIGN THIS FORM IF YOU HAVE TAKEN MEDICATIONS WHICH MAY IMPAIR YOUR MENTAL ABILITIES OR IF YOU FEEL RUSHED OR UNDER PRESSURE.

I certify that I have read the Informed Consent, discussed the issues noted above, had opportunities to ask questions, and agree and accept all of the terms above.

You should discuss any concerns or questions you have about this issue with your health professional.

INFORMED CONSENT TO TREAT

By signing this form, I understand the possible risks associated with this treatment. **THYMOSIN BETA 4 & GHKCU SPRAY** adverse reactions can include those listed above.

I understand that **Yoo Direct Health** will monitor my treatment in an effort to prevent any side effects but cannot guarantee that I will not experience any side effects or adverse reactions. I understand that, as with any health treatment, there is no guarantee I will obtain satisfactory results through the use of this therapy. I understand the use of this treatment does not preclude me from using other treatments as well, though I recognize that I should inform any provider I am seeing about the various treatments I am using.

NOTE: DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING THIS FORM. DO NOT SIGN THIS FORM IF YOU HAVE TAKEN MEDICATIONS WHICH MAY IMPAIR YOUR MENTAL ABILITIES OR IF YOU FEEL RUSHED OR UNDER PRESSURE.

I certify that I have read the foregoing Informed Consent, discussed the issues noted above, had opportunities to ask questions, and agree and accept all the terms above.

PATIENT NAME ____

PATIENT SIGNATURE ______________________________________ **DATE** ______________

YDH TRAINING ACADEMY

I have explained this Informed Consent and answered all questions and informed the patient of the available alternatives and of the potential risks. To the best of my knowledge, the patient has been adequately informed and has consented.

Provider Name: ____

Provider Signature: ____ **Date:** ____________