# Program Consultation Agreement

I authorize payment in the amount of $ to Youthful Edge, LLC for the following professional services, to be provided to the patient named below:

- Lifestyle and medical history assessment
- Laboratory analysis
- Nutrition analysis
- Physical biomarker/functional performance measurements
- Physical examination
- Professional recommendations specifically for me in each of the following areas:
  - Nutritional lifestyle
  - Nutritional supplementation
  - Lifestyle improvements

- Physical fitness and exercise
- Hormone replacement therapy

I understand that if I miss my scheduled appointment for this consultation without sufficient advance cancellation notice, I am still responsible for the professional service fee.

Complete this section only if you **are** a beneficiary enrolled **In Medicare Part B,** required to receive medical services:
I am eligible for Medicare benefits and have signed the Medicare Private Contract between Youthful Edge, LLC. and myself: Yes No

Patient Signature:
Date: