



SOUTHWEST LOCATION  
6020 S. RAINBOW SUITE C  
LAS VEGAS, NV 89118  
PH. 702-838-1994  
FAX. 702-870-0068

DR. JOHN J. PIERCE  
MEDICAL DIRECTOR  
www.agelessforever.net

NORTHWEST LOCATION  
7455 W WASHINGTON # 280  
LAS VEGAS, NV 89128  
PH. 702-222-1994  
FAX. 702-222-1992

## PATIENT INFORMATION SHEET

NAME: \_\_\_\_\_ Male  Female

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ WORK: \_\_\_\_\_ CELL: \_\_\_\_\_

SOCIAL SECURITY# \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

EMAIL: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

NEAREST RELATIVE NOT LIVING WITH YOU: \_\_\_\_\_

RELATIONSHIP TO YOU: \_\_\_\_\_ PHONE # \_\_\_\_\_

ADDRESS: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_ REASON FOR VISIT: \_\_\_\_\_

PLEASE LIST CURRENT  
MEDICATIONS: \_\_\_\_\_

DRUG ALLERGIES: \_\_\_\_\_

DO YOU REGULARLY TAKE VITAMINS OR SUPPLEMENTS? \_\_\_\_\_

IF YES WHICH ONES:  
\_\_\_\_\_  
\_\_\_\_\_

**NOTICE:** Pursuant to the provisions of subsection 7 of NRS 629.051: The health care records of patients who are less than 23 years of age may not be destroyed and the health care records of other patients may be destroyed after 5 years.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



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<b><u>ADAM QUESTIONNAIRE</u></b>	<b>1 - 5</b>
<b>Please rate your symptoms on a scale of 1-5 with 5 being the highest.</b>	
1. Decline in your feeling of general well being.	
2. Joint pain and muscular ache (back and limbs, etc.)	
3. Excessive sweating (unexpected sudden episodes hot flushes)	
4. Sleep problems (insomnia, poor quality of sleep, waking feeling tired)	
5. Increased need for sleep, or falling asleep after dinner.	
6. Irritability for no apparent reason.	
7. Nervousness for no apparent reason.	
8. Anxiety for no apparent reason.	
9. Physical exhaustion/ lacking vitality (decrease in performance, reduced activity, lack of interest in sports or having to force oneself to do activities).	
10. Decrease in muscular strength (feeling of weakness).	
11. Depressive mood (feeling sad, down, on the verge of tears, mood swings, feeling nothing is of any use).	
12. Feelings you have passed your peak.	
13. Feeling burnt out, having hit rock bottom.	
14. Decrease in beard growth.	
15. Decrease in ability/ frequency to perform sexually.	
16. Decrease in number or strength of morning erections.	
17. Decrease in libido (sexual desire).	
18. Have you lost height?	
19. Are you sad or grumpy?	
20. Has there been a recent deterioration in your work performance?	



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<b><u>ADULT GROWTH HORMONE DEFICIENCY QUESTIONNAIRE</u></b>	YES	NO
I HAVE TO STRUGGLE TO FINISH JOBS		
I FEEL A STRONG NEED TO SLEEP DURING THE DAY		
I OFTEN FEEL LONELY EVEN WHEN I AM WITH OTHERS		
I HAVE TO READ THINGS OVER AND OVER TO COMPREHEND		
IT IS DIFFICULT FOR ME TO MAKE FRIENDS		
IT TAKES A LOT OF EFFORT FOR ME TO DO SIMPLE TASKS		
I HAVE DIFFICULTY CONTROLLING MY EMOTIONS		
I OFTEN LOSE TRACK OF WHAT I WANT TO SAY		
I LACK CONFIDENCE		
I HAVE TO PUSH MYSELF TO DO THINGS		
I OFTEN FEEL VERY TENSE		
I FEEL AS IF I LET PEOPLE DOWN		
I FIND IT HARD TO MIX WITH PEOPLE		
I FEEL WORN OUT EVEN WHEN I'VE DONE NOTHING		
THERE ARE TIMES WHEN I FEEL VERY LOW		
I AVOID RESPONSIBILITY IF POSSIBLE		
I AVOID MIXING WITH PEOPLE I DON'T KNOW WELL		
I FEEL AS IF I AM A BURDEN TO PEOPLE		
I OFTEN FORGET WHAT PEOPLE HAVE SAID TO ME		
I FIND IT DIFFICULT TO PLAN AHEAD		
I AM EASILY IRRITATED BY OTHER PEOPLE		
I OFTEN FEEL TOO TIRED TO DO THE THINGS I OUGHT TO DO		
I HAVE TO FORCE MYSELF TO DO ALL THE THINGS THAT NEED DOING		
I OFTEN HAVE TO FORCE MYSELF TO STAY AWAKE		
MY MEMORY LETS ME DOWN		

**TOTAL SCORE \_\_\_\_\_**

SCORE ONE POINT FOR EACH QUESTION ANSWERED YES.  
 PATIENT MUST HAVE A TOTAL SCORE OF AT LEAST 11pts. TO BE ELIGIBLE FOR GROWTH HORMONE REPLACEMENT. THIS QUESTIONNAIRE WILL **NOT** BE THE ONLY CRITERIA REQUIRED TO RECEIVE GROWTH HORMONE.



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## E.D. QUIZ

This sexual health quiz can help determine if you have erectile dysfunction (ED). Only your doctor can decide if you have erectile dysfunction.

At the end of the quiz, your score is totaled and a course of action is suggested.

1. During Sexual intercourse, **how difficult** was it to maintain your erection to completion of intercourse?

- Did not attempt
- Extremely difficult
- Very difficult slightly difficult
- Not difficult

2. How do you rate your **confidence** that you could get and keep an erection?

- Very Low
- Low
- Moderate
- High
- Very High

3. When you had erections with sexual stimulation, **how often** were your erections hard enough for penetration (entering your partner)?

- No Sexual Activity
- Almost never or never
- A few times
- Sometimes
- Most times
- Almost Always

4. When you attempted sexual intercourse, **how often** was it satisfactory for you?

- Did not attempt intercourse
- Almost never or never
- A few times
- Sometimes
- Most times
- Almost always

5. During sexual intercourse, **how often** were you able to maintain your erection after you had penetrated (entered) your partner?

- Did not attempt
- Almost never or never
- A few times
- Sometimes
- Most times
- Almost always



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**SOCIAL HISTORY**

ALCOHOL USE: AMOUNT DAILY \_\_\_\_\_ AMOUNT WEEKLY \_\_\_\_\_

DO YOU SMOKE? YES \_\_\_\_\_ NO \_\_\_\_\_ PACKS PER DAY: \_\_\_\_\_

HAVE YOU EVER HAD AN INJURY OR TRAUMA TO THE HEAD? Y \_\_\_\_\_ N \_\_\_\_\_

If yes please explain \_\_\_\_\_

\_\_\_\_\_

TYPE OF ACCIDENT: \_\_\_\_\_

DATE OF ACCIDENT: \_\_\_\_\_

MEDICAL PROBLEMS DUE TO ACCIDENT: \_\_\_\_\_

**FAMILY HISTORY**

PLEASE LIST ANY AND ALL SIGNIFICANT MEDICAL CONDITIONS ON EITHER MOTHER OR FATHERS SIDE: SIDE SUCH AS CANCER, HEART DISEASE, DIABETES, ECT:

TYPE OF DISEASE/CONDITION \_\_\_\_\_

RELATIVE \_\_\_\_\_

TYPE OF DISEASE/CONDITION \_\_\_\_\_

RELATIVE \_\_\_\_\_

TYPE OF DISEASE/CONDITION \_\_\_\_\_

RELATIVE \_\_\_\_\_

TYPE OF DISEASE/CONDITION \_\_\_\_\_

RELATIVE \_\_\_\_\_

(HISTORY)  
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**ILLNESS REQUIRING A DOCTOR'S CARE**

PLEASE LIST ALL MEDICAL CONDITIONS YOU HAVE PREVIOUSLY OR ARE CURRENTLY BEING TREATED BY A PHYSICIAN FOR AND ANY HOSPITALIZATION AND/OR SURGERY NEEDED FOR THAT CONDITION. PLEASE LIST THE NAME AND ADDRESS OF THE TREATING PHYSICIAN AND YEAR OF ONSET OF CONDITION:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_

**MEDICATION HISTORY**

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

TYPE OF MEDICATION AND DOSE \_\_\_\_\_

PRESCRIBING DOCTOR \_\_\_\_\_

TYPE OF MEDICATION AND DOSE \_\_\_\_\_

PRESCRIBING DOCTOR \_\_\_\_\_

TYPE OF MEDICATION AND DOSE \_\_\_\_\_

PRESCRIBING DOCTOR \_\_\_\_\_

(HISTORY)  
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**VITAMINS/MINERALS AND SUPPLEMENTS**

PLEASE LIST ANY AND ALL VITAMINS/MINERALS AND SUPPLEMENTS YOU ARE CURRENTLY TAKING :

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_
- 7. \_\_\_\_\_
- 8. \_\_\_\_\_

**DIET AND EXERCISE**

PLEASE LIST ANY SPECIFIC DIET REGIMEN YOU ARE CURRENTLY ON. IF YOU DO NOT HAVE ANY SPECIFIC DIET PLEASE PUT "NO SPECIFIC DIET".

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PLEASE LIST YOUR DAILY EXERCISE ROUTINE.

\_\_\_\_\_

\_\_\_\_\_

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## PATIENT PRIVACY

Dr. John J Pierce (“Labeled Physician”) agrees to maintain privacy of

(“Patient”): \_\_\_\_\_ as outlined in the HIPAA forms. Dr. Pierce takes pride in being able to extend a greater degree of privacy than is required by HIPAA, Nevada state confidentiality mandates and common law.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, HIPAA forbids physicians from receiving money for selling lists of patients or protected health information to companies to market their products or services directly to patients without authorization. Some medical practices though can lawfully circumvent this limitation by having a third party perform their marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Dr. John J Pierce believes this is improper and may not be in the patient’s best interest. Accordingly Dr. John J Pierce agrees not to be paid for selling patient lists or protected health information to any party for the purpose of marketing directly to his patients. Regardless of legal privacy loopholes, Dr. John J Pierce will never attempt to leverage his relationship with his patient by seeking Patient consents for marketing products for others.

In consideration for treatment and the above noted patients protection, Patient agrees to refrain directly or indirectly from publishing or airing commentary upon Dr. John J Pierce and his practice, expertise or treatment. Dr. John J Pierce has invested significant financial and marketing resources in developing his practice and published comments on web pages, blogs, and or mass correspondence could severely damage Dr John J Pierce practice. Dr John J Pierce has the right to equitable relief to prevent the initiation or continuation of publishing or airing of commentary upon his practice and expertise and or treatment.

Dr John J Pierce feels strongly about his patient’s privacy as well as his practices rights to control public image and privacy. Both Dr. John J Pierce and patient will work to prevent the publishing or airing of commentary about the other party from being accessed via Internet, Blogs or other electronic print, or broadcast media without prior written consent. Finally, this agreement shall be in force and enforceable for a period of five years from Dr. John J Pierces’ last date of service to patient.

Patient has been given the opportunity to ask questions and receive adequate explanation to his/her satisfaction.

So agreed this \_\_\_\_\_ (Day), of \_\_\_\_\_ (month) 20\_\_\_\_\_.

Patient Signature: \_\_\_\_\_

Witness Signature: \_\_\_\_\_



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## PROVIDER NOTICE OF PRIVACY PRACTICES

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the equality of care that you receive. Continuity of care is part of treatment and your records may be shared with other providers whom you are referred. Information may be shared by paper mail, electronic mail, fax or other methods.

We may use or disclose identifiable health information about you without your authorization for several reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notices in the waiting area. You can also request a copy of our notices at any time. For more information about our privacy practices, contact the person below.

### **Individual Rights**

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we will charge you only normal photocopy fees. You may also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes and other than when you explicitly authorized it. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

### **Complaints**

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with an appropriate address upon request.

### **Our Legal Duty**

We are required by law to protect privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and obtain your acknowledgment of receipt of this notice.



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**IF YOU HAVE ANY QUESTIONS OR COMPLAINTS PLEASE  
CONTACT ONE OF OUR OFFICES**

Southwest Address: 6020 S. Rainbow Suite C Las Vegas, NV 89118  
Phone: 702-838-1994 Fax: 702-870-0068

Northwest Address: 7455 W. Washington Ave Suite 280 Las Vegas, NV 89128  
Phone: 702-222-1994 Fax: 702-222-1992

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have received and understand Ageless Forever Inc. and Dr. John J. Pierces' Notice of Privacy Practices.

Signature: \_\_\_\_\_

Printed name: \_\_\_\_\_

Date: \_\_\_\_\_



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PATIENT NAME: \_\_\_\_\_

This Mutual Binding Arbitration Agreement constitutes an integral part of a contract for medical services

By and between John J. Pierce DO, and any of his employees, and \_\_\_\_\_ who agrees to be bound as described hereunder:

1. It is understood that any dispute as to medical malpractice, that is, as to whether any medical services rendered under this contract were unnecessary or authorized or were improperly negligent or incompetently rendered, will be determined by submission to arbitration by the American Arbitration Association office in Las Vegas, Nevada as provided in Nevada law, and not by lawsuit or resort to court process except as Nevada law provides for judicial review of arbitration proceedings. Any arbitration proceedings must take place in the State of Nevada. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.
2. Procedures to attempt to slow the aging process are considered desirable and elective; the patient understands that they have chosen to undergo this procedure even though no medical necessity exists. Dr. Pierce will not be taking over any general medical care; he will only be assisting to attempt to slow the aging process. All other medical care will be relegated to the patient's primary care physician.
3. Such arbitration shall neo in accordance with the current arbitration rules of the America Arbitration Association, even though the American Arbitration Association will not be overseeing the proceedings, yet always within accordance of Nevada Regulatory Statutes. This Mutual Binding Arbitration Agreement shall apply to any legal claim or civil action in connection with any and all medical services rendered, whether inpatient or out patient, against Dr. Pierce or any of his employees or contracted staff.
4. As all services that Dr. Pierce and his employees perform are elective and not life saving, the execution of this Mutual Binding Arbitration Agreement shall be a precondition of the furnishing of medical services by Dr. Pierce, this Mutual Binding Arbitration Agreement may be rescinded by written notice from the Patient or the patients legal representative prior to undergoing any treatment or diagnostic evaluation. Dr. Pierce may assume that if the patient proceeds with the treatment / evaluation, that he / she is willing to abide by this binding arbitration agreement.
5. The Mutual Binding Arbitration Agreement shall bind the parties hereto, including newborns and their heirs, representatives, executors, administrators, successors, and assigns of such parties and newborns.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRECTICE DECIDED BY NEUTRAL ARBITRATION AND YOU AGE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. NEVADA REGULATORY STATUTE PROVIDED UPON REQUEST. THE PREVAILING PARTY IS ENTITLED TO RECOVER FEES.

Date: \_\_\_\_\_ Time: \_\_\_\_\_ am / pm

Signature: \_\_\_\_\_  
(PATIENT/PARENT/LEGAL REPRESENTATIVE)

If signed by other than patient, indicate relationship: \_\_\_\_\_



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## **CONSENT FOR MEASURING**

\_\_\_\_\_ I HEREBY AUTHORIZE AGELESS FOREVER AND ITS ASSOCIATED PHYSICIANS TO PERFORM UPON ME THE SAMPLING OF BLOOD FOR THE PURPOSE OF MEASURING CERTAIN ASPECTS OF THE AGING PROCESS ON MYSELF.

\_\_\_\_\_ I UNDERSTAND BLOOD TESTING IS INTENDED TO GIVE AN ESTIMATE OF THE AGING PROCESS ON DIFFERENT ORGANS AND TISSUES OF MY BODY. I ALSO UNDERSTAND THAT THE SCIENCE OF ANTI-AGING MEDICINE IS A CLINICALLY NEW EVALUATION PROCESS AND THAT NO GUARANTEES ARE MADE AS TO THE ACCURATENESS OF THE TEST RESULTS.

\_\_\_\_\_ I UNDERSTAND THAT DURING THE SAMPLING PROCESS, UNANTICIPATED EVENTS MAY OCCUR INCLUDING HEMATOMA FORMATION OR SCARRING.

\_\_\_\_\_ I CONSENT, AUTHORIZE AND REQUEST THE ADMINISTRATION OF SUCH ANTI-AGING MEDICATIONS OR SUPPLEMENTS THAT MAY BE PRESCRIBED BY MY PHYSICIANS.

\_\_\_\_\_ I UNDERSTAND ADDITIONAL TESTING MUST BE DONE PERIODICALLY DURING THE YEAR TO ENSURE THE PROPER LEVELS OF MEDICATIONS / SUPPLEMENTS ARE BEING ADMINISTERED.

\_\_\_\_\_ I UNDERSTAND I WILL BE CHARGED FOR THE ABOVE TREATMENTS ON AN INDIVIDUAL BASIS, AFTER MY PERMISSION HAS BEEN OBTAINED. I ALSO UNDERSTAND NONE OF THE ABOVE TREATMENTS OR PROCEDURES IS COVERED BY INSURANCE, AND THAT I WILL BE RESPONSIBLE FOR PAYMENT IN FULL AT THE TIME OF SERVICE.

\_\_\_\_\_ I UNDERSTAND WITH ALL NEW MEDICAL TREATMENT OF PROTOCOLS, THERE MAY BE POSSIBLE RISKS AND COMPLICATIONS AND THAT THESE VARY FOR EACH INDIVIDUAL. I UNDERSTAND THAT ALTHOUGH THE TREATMENTS I MAY BE GIVEN ARE BASED ON SOUND SCIENTIFIC RESEARCH THAT MUCH OF THE ANTI-AGING IS EXPERIMENTAL AND NEW. FINALLY, I CONSENT TO THE PRESCRIPTION OF MEDICATIONS, SUPPLEMENTS, AND TREATMENTS FOR SLOWING THE AGING PROCESS WITHIN MYSELF AS RECOMMENDED AND DIAGNOSED BY DR. PIERCE. AT THE TIME OF SIGNING THIS CONSENT, I AM IN FULL CONTROL OF MY FACULTIES AND UNDERSTAND THE ABOVE CONSENT IN DETAIL.

SIGNED: \_\_\_\_\_

DATE: \_\_\_\_\_



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## **DR PIERCE'S FEE BREAKDOWN**

### **INITIAL INTAKE FEE \$100.00**

This fee is a deposit towards the consultation with Dr. Pierce. This fee DOES require a 24 hour cancellation notice to receive a full refund. This fee will be applied to your consultation fee.

### **INITIAL CONSULTATION FEE \$499.00 (limited time offer) Regular fee \$799.00**

The INITIAL INTAKE FEE will be applied at the time of your consultation so the balance will be \$399.00. Regular fee \$699.00.

**\*Please understand that you will be responsible for any blood work not covered by your insurance so we urge you to know what your benefits entail. (i.e., Co-pays and Deductibles)**

### **PROGRAM**

Initial blood work without insurance blood work (Draw fee included) \$800.00  
Additional follow-up blood work with or without insurance (Draw fee) \$50.00

With the PROGRAM to include the following:

- Blood Work
- Dr.'s Initial Consultation and First Follow-Up Consultation

Additional OFFICE VISIT FEES are as follows:

30 Min Follow Up    \$80.00  
60 Min Follow Up    \$150.00

\_\_\_\_\_ Initial



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## **PRESCRIPTION ACKNOWLEDGEMENT**

I, THE UNDERSIGNED PATIENT, UNDERSTAND I HAVE A CHOICE OF WHERE TO PURCHASE MY PRESCRIPTIONS. I UNDERSTAND THE THERAPIES RECOMMENDED BY DR. PIERCE ARE NOT COMMONLY AVAILABLE AT ALL PHARMACIES AND ARE COMPOUNDED IN A NON-TRADITIONAL COMPOUNDING PHARMACY. I UNDERSTAND I HAVE THE OPTION TO HAVE DR. PIERCE FORWARD MY PRESCRIPTION TO A COMPOUNDING PHARMACY FOR IT TO BE FILLED. I UNDERSTAND IF I CHOOSE TO HAVE AGELESS FOREVER OBTAIN MY PRESCRIPTIONS FROM A COMPOUNDING PHARMACY, I CAN PAY FOR MY MEDICATIONS AND AGELESS FOREVER CAN THEN PAY THE COMPOUNDING PHARMACY ON MY BEHALF. ALTERNATIVELY, I CAN RECEIVE A PRESCRIPTION AND TAKE IT MYSELF TO ANY PHARMACY, WHICH I CHOOSE TO BE FILLED. IN EITHER REGARD, AGELESS FOREVER WILL BE CHARGING ME A PROFESSIONAL COMPONENT FOR MONITORING MY CARE AND FOR MY ACCESSIBILITY TO DR. PIERCE AND HIS STAFF FOR ANY QUESTIONS OR CONCERNS I HAVE. I ALSO UNDERSTAND MY BILL WILL CLEARLY STATE WHAT THE CHARGES FOR MY MEDICATIONS ARE AND WHAT THE FEES FOR THE PROFESSIONAL COMPONENT WILL BE. I UNDERSTAND DR. PIERCE CAN ONLY RENEW MY PRESCRIPTION IF I CONTINUE TO HAVE HIM SERVE AS MY PHYSICIAN. AS I HAVE BEEN PREVIOUSLY INFORMED, DR. PIERCE DOES NOT ACCEPT INSURANCE FOR ANY OF HIS SERVICES. IF I WISH TO SUBMIT MY CHARGES TO MY INSURANCE CARRIER, IT WILL BE MY RESPONSIBILITY TO DO SO. ALL PAYMENTS TO AGELESS FOREVER ARE DUE AT THE TIME OF SERVICES. I UNDERSTAND THE ABOVE STATEMENTS, AND IF I HAVE ANY QUESTIONS, THEY WILL BE ANSWERED BY DR. PIERCE OR THE AGELESS FOREVER STAFF TO MY SATISFACTION.

---

(SIGNATURE)

---

(PRINT NAME)

---

(DATE)



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## **PATIENT MANAGEMENT FEES**

THE FOLLOWING FEES APPLY TO EVERY PATIENT ON A MONTHLY BASIS FOR AS LONG AS YOU ARE AN ACTIVE PATIENT WITH OUR PRACTICE. THESE FEES ARE BEING CHARGED TO MONITOR YOUR CARE AND THE LEVEL OF CARE DETERMINES THESE FEES.

### **BASIC MANAGEMENT FEE \$25.00**

THIS FEE WILL BE CHARGED IF THE PATIENT IS ONLY RECEIVING ONE MEDICATION ON A MONTHLY BASIS WHERE MINIMAL CARE IS NECESSARY. THIS FEE DOES NOT INCLUDE TESTOSTERONE REPLACEMENT THERAPY.

### **INTERMEDIATE PT MGMT FEE \$50.00**

THIS FEE WILL BE CHARGED IF THE PATIENT IS RECEIVING MULTIPLE MEDICATIONS INCLUDING CREAMS OTHER THAN HGH. THIS FEE INCLUDES ANY SUPPLIES REQUIRED SUCH AS INJECTING SYRINGES OR OFFICE STAFF.

### **COMPREHENSIVE PATIENT MANAGEMENT FEE \$100.00**

THIS FEE WILL BE CHARGED ON A MONTHLY BASIS FOR PATIENTS RECEIVING HUMAN GROWTH HORMONE. ADULT GROWTH HORMONE DEFICIENCY IS A VERY COMPLEX MEDICAL CONDITION. MULTIPLE CRITERIA MUST BE MET TO ENSURE PROPER CARE IS BEING GIVEN AND THAT IS WHY A HIGHER FEE IS APPLIED. ALL SUPPLIES REQUIRED TO USE HUMAN GROWTH HORMONE ARE ALSO INCLUDED.

**\*PURCHASING MORE THAN A ONE MONTH SUPPLY AT A TIME DOES NOT EXCLUDE THE MONTHLY PATIENT MANAGEMENT FEES. THEY WILL BE CHARGED.**

20% DISCOUNTS WILL APPLY FOR PATIENTS WHO WISH TO PURCHASE THEIR PATIENT MANAGEMENT FEES ON AN ANNUAL BASIS.

I HAVE READ AND UNDERSTAND THE FEES AS THEY APPLY TO MY CARE UNDER DR. JOHN J. PIERCE OR ANY OFFICE AFFILIATE.

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_



SOUTHWEST LOCATION  
6020 S. RAINBOW SUITE C  
LAS VEGAS, NV 89118  
PH. 702-838-1994  
FAX. 702-870-0068

DR. JOHN J. PIERCE  
MEDICAL DIRECTOR  
www.agelessforever.net

NORTHWEST LOCATION  
7455 W WASHINGTON # 280  
LAS VEGAS, NV 89128  
PH. 702-222-1994  
FAX. 702-222-1992

## AUTHORIZATION FOR PAYMENT POLICY

I, \_\_\_\_\_ AGREE TO AND UNDERSTAND THAT AGELESS FOREVER DOES NOT ACCEPT HEALTH INSURANCE. IT IS MY RESPONSIBILITY TO SUBMIT VERIFICATION OF MEDICATIONS AND TREATMENTS TO MY INSURANCE PROVIDER SHOULD MY PROVIDER COVER THESE COSTS. NO CLAIMS WILL BE SUBMITTED BY AGELESS FOREVER TO MY INSURANCE PROVIDER.

**PAYMENT OF MY MEDICATIONS SHALL BE DUE WHEN I PLACE THE ORDER FOR THEM. I CAN CHOOSE TO HAVE A CREDIT CARD KEPT ON FILE BY AGELESS FOREVER AND THE COST OF MEDICATIONS WILL BE CHARGED TO THIS CREDIT CARD ON THE DAY I PLACE AN ORDER. IF I DO NOT WISH TO KEEP A CREDIT CARD ON FILE I WILL HAVE TO COME INTO THE OFFICE AND PREPAY FOR THE MEDICATIONS BEFORE THEY MAY BE ORDERED. THESE MEDICATIONS CANNOT BE RETURNED TO THE PHARMACY, THEREFORE ONCE I PAY FOR THE MEDICATIONS IT IS NON-REFUNDABLE. AGELESS FOREVER WILL MAKE EVERY EFFORT TO CONTACT ME FOR MY MEDICATIONS, BUT IT IS MY RESPONSIBILITY TO PICK UP IN A TIMELY FASHION. IF I DO NOT PICK UP MY MEDICATION WITHIN 14 DAYS, IT WILL BE DISPOSED OF.**

INITIAL: \_\_\_\_\_

SHOULD I CHOOSE TO USE THE METHOD OF PAYMENT BY CREDIT CARD, I AUTHORIZE AGELESS FOREVER TO KEEP MY CREDIT CARD INFORMATION ON FILE AND TO USE IT STRICTLY FOR PAYMENT OF MEDICATIONS OR THE SERVICES AGREED UPON. I UNDERSTAND THAT MY CREDIT CARD INFORMATION IS STRICTLY CONFIDENTIAL.

SHOULD THERE BE ANY PROBLEMS OR A CHANGE IN CREDIT CARD STATUS I WILL NOTIFY AGELESS FOREVER PROMPTLY. I AGREE TO HANDLE ANY OUTSTANDING FINANCES IN ANOTHER FORM OF PAYMENT TO AGELESS FOREVER SHOULD THIS EVENT OCCUR.

\_\_\_\_\_  
(PATIENT SIGNATURE)

\_\_\_\_\_  
(DATE)

\_\_\_\_\_  
(WITNESS SIGNATURE)

\_\_\_\_\_  
(DATE)

NAME AS IT APPEARS ON CARD: \_\_\_\_\_

CREDIT CARD# \_\_\_\_\_

EXPIRATION DATE: \_\_\_\_\_ CVV CODE: \_\_\_\_\_