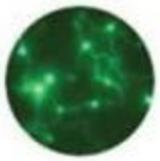
EMERALD NEURO-RECOVER CENTERS
12289 HANCOCK STREET CARMEL, IN 46032 SUITE #36

EMERALD-NEURO-RECOVER.COM
OFFICE 317.457.0594



PATIENT & FINANCIAL SPONSOR CONSENT FORM FOR NAD THERAPY

This content form is designed to provide a written confirmation of such discussion by recording some of the more significant medical information given to you. It is intended to make you better informed so that you may give or withhold your consent to this proposed treatment(s).

Condition: A staff member @ Emerald Neuro-Recover Centers has explained to me the protocol with NAD treatment along with the side effects.

Please initial below after reading:

___I understand this treatment is optional and I come to the clinic on my own behalf.
I truly want to get well. I will accept the fact that I am in treatment and abide by all the rules and regulations that are asked of me. I understand there are no refunds if patient is non compliant.

___I understand I am not allowed to leave the clinic of Emerald Neuro-Recover Centers without supervision during my scheduled treatment time.

___I understand I must arrive on time of my scheduled procedure and stay for full treatment.
I will follow the hydration schedule and diet recommended by Emerald Neuro-Recover Centers.

___I will not take any belongings of Emerald Neuro-Recover Centers,
and understand this will result in immediate dismissal.

___I understand it is imperative to my treatment that I withhold from illicit drugs and alcohol.
Any use of drugs and alcohol are contraindicated for treatment.

___I consent to random drug tests throughout the treatment program and a pregnancy test before starting treatment.

___I will take as directed by the medical doctor prescribed medication as directed on label.

___I understand communication will be limited during the treatment. Cellular phones and tablets are not allowed. Recommended to change telephone number, remove social media, and remove all negative influences.

___I understand visitors must be approved by Emerald Neuro-Recover Centers.

___I understand the rooms are private and communication with other patients are not allowed unless expressed.

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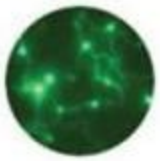

Risk of Proposed Procedure(s):

___Just as there are many be benefits to the procedure(s) proposed, I, also understand the procedures involve risk. Risk could possible could include one or more of the following: nasal fullness, chest heaviness, anxiety, gastrointestinal symptoms, headache, insomnia, exhaustion, and red eyes.

___I am in a healthy condition to start treatment. I do not have epilepsy, paralysis, Parkinson's disease. I am not pregnant. I do not have metallic implant(s) in my body including a pacemaker.

Acknowledgements: I've been explained the protocol and procedure of NAD treatment.
The potential benefits and risks of the proposed procedure(s), and the likely result with such treatment, have been explained to me. I understand what has been discussed with me as well as the contents of this consent form, and have been given the opportunity to ask questions and have received satisfactory answers.

Consent to Procedure(s) and Treatment: Having read this form and talked with _____,
My signature below Acknowledges that: I voluntarily give my authorization and consent to the performance of the procedure(s) described above. Should any discomfort occur during treatment, I will discontinue session after immediately notifying the staff of any unusual sensations or withdraw symptoms.
I will not hold Emerald Neuro-Recover Centers liable for unusual sensations or withdraw symptoms.

Print Patient Name:_____
Patient Signature: _____ Date: _____

Print Financial Sponsor Name:_____
Financial Sponsor Signature:_____ Date:_____

Office Use:

The above consent was read to patient by (printed name): _____

Date:_____

Signature:_____