Bio-Identical Hormone Replacement Therapy Patient Consent

Please read and review this consent form and ask questions for clarification if needed. Then, initial each statement indicating understanding and agreement, and sign at the bottom of the form.

Statement of Patient:

_____**(Initials)** I understand that along with the benefits of any medical treatment or therapies, there are both risks and potential complications to treatment, as well as not being treated. Those risks and potential complications have been explained to me. I have not been promised or guaranteed any specific benefit from the administration of these therapies and no warranty or guarantee has been made regarding the results of treatment. I agree to proceed with treatment and to comply with recommended dosages.

_____**(Initials)** I agree to comply with requests for ongoing testing to assure proper monitoring of my treatments that may include laboratory evaluation of all hormone levels or other diagnostic testing by a physician, my primary care physician, or other specialist. I agree to see my primary care physician, gynecologist, or other practitioner for regular monitoring and for preventative measures that may include but are not limited to complete physicals, rectal examinations and/or colonoscopy, EKG, mammograms, pelvic/breast exams, pap smears, prostate exams, PSA levels, etc.

_____**(Initials)** I agree to immediately report to my physician any adverse reaction or problem that might be related to my therapy. I understand that along with the benefits of any medical treatment or therapies, there are both risks and potential complications to treatment, as well as to not being treated. Those risks and potential complications have been explained to me and I agree that I have received information regarding those risks, potential complications and benefits, and the nature of bio-identical and other hormone treatments and have had all my questions answered. Furthermore, I have not been promised or guaranteed any specific benefit from the administration of bio-identical hormone therapy.

_____**(Initials)** I have been informed that insurance companies may not pay for physician evaluation, laboratory testing, and medications. I therefore agree to pay for all services including physician evaluation, laboratory tests and pharmacy charges, with the understanding that I may not be reimbursed by my insurance company.

_____**(Initials)** I certify this form has been fully explained to me, that I have read it or have had it read to me. I have been educated on the benefits, risks, and possible adverse reactions associated with bio-identical hormone replacement therapy. I have been given the opportunity to ask any questions about hormone replacement therapy, potential complications, required testing, and costs and have had them answered to my satisfaction. I agree not to undergo any treatments unless I fully understand the treatment and have discussed possible risks and benefits. I fully understand what I am signing and hereby request and consent to treatment using bioidentical hormone replacement therapy.

Signature of Patient:_____Date: _____

Name (PRINT):_____

If patient is a minor, Parent/Legal Guardian Signature:

_____Date: _____