CONSENT FOR HORMONE IMPLANTATION

I, _____authorize _____

or a designated Physician or Practitioner to perform the following operations or procedure.

STERILE SURGICAL PLACEMENT OF HORMONE PELLETS UNDER THE SKIN
I understand the reason for the procedure is: Hormone Replacement Therapy (Estradiol and or Testosterone)
RISKS: Risks of the particular procedure include: Bleeding and/or infection.
Bleeding and/or infection as well as a2%-4% possibility of rejection and/or extrusion of 1 or more pellets. I understand that _____ is not responsible for rejection/extrusion or any pellets after insertion.

LOCAL ANESTHESIA: The administration of anesthesia also involves risks, most importantly a rare risk of reaction to medication causing death. I consent to the use of such anesthetics as may be considered necessary by the physician responsible for these services. I understand that no guarantee or assurance has been made as to the results of the procedure and that it may not cure the condition.

PATIENT'S CONSENT: I have read and fully understand this consent form and understand I should not sign this form if all items, including all my questions, have not been explained or answered to my satisfaction or I do not understand any of the terms or words contained in this consent form. I am aware that these charges could be non-covered by my insurance and any remaining are my responsibility.

PATIENT SIGNATURE:_____DATE:_____

PROVIDER'S DECLARATION: I have explained the contents of this document to the patient and have answered all the patient's questions, and to the best of my knowledge, I feel the patient has been adequately informed and has consented.

PROVIDER'S SIGNATURE: _____ DATE: _____

MAMMOGRAM/PAP SMEAR WAIVER
FOR ESTRADIOL/TESTOSTERONE PELLET THERAPY

I,_____voluntarily choose to undergo implantation of sub-dermal bio-equivalent Estradiol/Testosterone pellet therapy.

For today's appointment:

☐ I have had Mammogram on (date) _____
☐ I have had Pap Smear on (date) _____

OR

☐ My decision NOT to have one or both.
☐ My doctor's decision NOT to have one or both.

I have voluntarily chosen to sign this release form and agree that if any breast/uterine issues arise and/or develop while on pellet therapy, I release _____ from any liability.

PATIENT SIGNATURE:_____DATE: _____

FEMALE ESTRADIOL/TESTOSTERONE ACKNOWLEDGEMENT INSERTION FORM

Although this therapy has been approved for human use, there are few doctors who currently administer estradiol and testosterone pellets in the United States. I realize that this is not the usual and customary means of hormone replacement. I have been told that I may have Bio-Identical hormonal testosterone inserted under my skin to achieve a steady delivery of natural testosterone hormone in my blood system. I realize that testosterone can increase my energy, my libido and increase my sense of well-being. I may also see testosterone decreasing the frequency and severity of my headaches. I have been told that I may have Bio-Identical hormone estradiol inserted under my skin to also achieve a steady state of estradiol in my body. I realize that estradiol can eliminate my mood swings, anxiety and irritability.

I realize in the past, male athletes have abused testosterone. When they took huge quantities of synthetic testosterone, they may have incurred heart problems and elevated cholesterol. However, low-dose, non-oral, natural testosterone that is used in Bio-Identical hormonal therapy has not been associated with these problems. In a rare number of patients, the body will convert testosterone to DHT which can cause acne or hair loss. I also realize the estradiol dosage that I may receive can aggravate fibroids or polyps, if they exist, and cause bleeding.

Side effects are rare but may include: breast tenderness for 7M10 days after insertion, uterine spotting and slight weight gain from muscle growth. Facial hair growth, loss of hair and acne are rare as well.

I understand there is a charge, depending on the number of Bio-Identical hormonal therapy pellets I may receive. The precise amount is to be determined by the number of pellets.

My signature certifies that I have read the above and acknowledge I have been encouraged to ask any questions regarding Bio-Identical hormonal therapy. Individual results may vary.

PATIENT SIGNATURE:_____DATE: _____

INFORMED CONSENT FOR FEMALE ESTRADIOL & TESTOSTERONE HORMONE INSERTION

This consent form provides written confirmation that a discussion regarding bio-identical hormone insertion has occurred, and I agree to proceed.

General Bio-identical hormone pellets are comprised of naturally derived concentrated hormones. These hormones are designed to be biologically identical to the hormones a woman makes in her own body prior to menopause, including estrogen and testosterone which are made in the ovaries and adrenal gland. Bio-identical hormones have the same effects on the body as one's own estrogen and testosterone did when the woman was younger, without the monthly fluctuations (ups and downs) of menstrual cycles.

Birth Control Patients who are pre-menopausal must continue reliable birth control while participating in pellet hormone replacement therapy . Testosterone is listed as category X (will cause birth defects) and cannot be given to pregnant women.

My birth control method is:

☐ Abstinence ☐ Hysterectomy ☐ Menopause ☐ Birth control pill ☐ IUD ☐ Tubal Ligation ☐ Other: _____

BENEFITS I consent to having testosterone inserted under my skin to achieve a steady delivery of natural testosterone hormone into my blood system. The potential benefits of testosterone include a possible increase in my bone density, short term memory, protection against Alzheimer's, increase in my energy, my libido, and my sense of well being. Testosterone may also decrease the frequency and severity of my headaches. I also consent to having estradiol pellet(s) inserted under my skin to also achieve a steady state of estradiol in my body. The potential benefits of estradiol include possible elimination of my mood swings, anxiety and irritability, cardiovascular protection and protect from developing colon cancer and brain dysfunction. I understand that none of these potential benefits are guaranteed.

RISKS I understand that the above potential benefits come with some risks. These risks include, but are not necessarily limited to the following: bleeding, infection and pain at the insertion site; lack of effect (from lack of absorption). Estrogen effects may include: breast tenderness and swelling especially in the first three weeks; water retention; increased growth of estrogen dependent tumors (fibroids endometrial cancer, breast cancer). Testosterone effects include: birth defects in babies exposed to testosterone during their gestation; increase in hair growth on the face; growth of liver tumors, if already present: change in voice and/or clitoral enlargement – both of which are reversible.

This manual is only suggestive in information to hand to the patient. We advise you to speak with your attorney about the use and language on any and/or all forms which pertain to your practice and state.

In a small number of patients, the body may convert testosterone to DHT which can cause acne or hair loss. The estradiol dosage that I may receive can aggravate fibroids or polyps, if they exist, and cause bleeding. If I have a uterus, I must take progesterone or risk abnormal endometrial cells or in rare cases endometrial cancer.

CHARGES I understand there is a charge which varies depending on the number of pellets I receive. The precise amount is to be determined by my medical provider. I understand payment is due in full at the time of service.

By signing below, I certify that I have read and understood the above and that I have been encouraged to ask any questions regarding pellet therapy and all of my questions have been answered to my satisfaction. I also acknowledge that the risks and benefits of this treatment have been explained to me and that I may experience one or more of the complications listed above. I accept these risks and benefits and consent to the insertion of hormone pellets under my skin.

PATIENT SIGNATURE: _____ DATE OF BIRTH:_____ DATE: :_____

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