BioMD Balance
SOLUTIONS

Consent For Medical Care And Treatment

NOTE TO PATIENT: There are risks involved in any procedure or treatment. It is not possible to guarantee or give assurance of a successful result. It is important that you clearly understand and agree to the planned treatment. You have received over one hour of specific education regarding the proposed hormonal treatment based upon our assessment. We have reviewed benefits and risks. You have had an opportunity to ask questions and to request additional information.

I authorize_________________________________, and such physicians, associates, assistants and other personnel of the ___________________________(group name) chosen by him or her to perform the following

Hormonal Assessment and Treatment, and/or to do any other procedure that in their judgment may be advisable to my well-being, including such procedures as are considered medically advisable to obtain the maximal benefits with the least risks in regards to the above proposed program of hormonal replacement therapy.

[__] GENERAL RISKS AND COMPLICATIONS: I am satisfied with my understanding of the more common risks and complications of the treatment, which have been described and I have discussed with the doctor.

[__] SPECIFIC RISKS AND COMPLICATIONS: I am satisfied with my understanding of specific risks of this treatment protocol/program as described by the doctor, which may include: risks of breast and prostate cancer in association with the use of testosterone, estrogens and growth hormone, weight gain, increased muscular mass, decreased body fat, hair growth, change in hair color, hypoglycemia, disclosure of latent diabetes transient fluid retention, carpal tunnel syndrome, transient joint pain, headaches, and death

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[ ] ALTERNATIVE TREATMENT: I am satisfied with my understanding of alternative treatments and their possible benefits and risks including: Testosterone Injections, Oral Estrogen/Progesterone replacement, Topical testosterone, Estrogen, Progesterone replacement or pellets Testosterone replacement, Vitamin and mineral replacement.

[__] NO TREATMENT: I am satisfied with my understanding of the possible consequences, outcomes or risks if no treatment is rendered.

[__] SECOND OPINION: I have been offered the opportunity to seek a second opinion concerning the proposed treatment from another physician with credentials from the A4M or any physician of my choice.

[__] LIMITATION OF MEDICAL CARE: I understand BioMD Balance Solutions' doctor is providing a specific hormonal treatment and protocol and that he/she is not taking responsibility for any other aspect of my ongoing medical health. My personal physician shall continue to provide all of my standard and continuous medical care. I hereby authorize the doctor to speak directly with my primary care physician when medically necessary regarding my past and present medical care and treatment.

OTHER QUESTIONS: I am satisfied with my understanding of the nature of the treatment and all of my additional questions about the treatment have been answered.

SIGNATURE:______________________________________DATE:______________

TIME______________AM/PM_______

PRIMARY PHYSICIAN:____

TELEPHONE#:_____________________