Institute for Hormonal Balance
Consent to Treat

The Nature of the Treatment

I hereby give my consent to evaluation and treatment of the following specified condition(s):
menopause
andropause
perimenopause
adrenal fatigue
sub optimal thyroid
other (specify): _____

By the administration of hormone replacement therapy and/or nutritional supplements, including vitamins, minerals and anti-oxidants and/or drugs designed to alter hormone levels, all as appropriate to my specific diagnosis, particular condition and treatment objectives.

Alternative Treatment Methods and Their General Natural

The reasonable alternatives to this treatment have been explained to me and they include:
1. Leaving the hormone levels as they appear.
2. Treating age related diseases as they appear.
3. Using pharmaceutical agents that are not bioidentical in nature.

I understand the foregoing alternatives and am choosing to consent to the treatment plan prepared for me to address the condition(s) indicated above.

The General Nature and Extent of Treatment-Related Risks

Women: □ **INITIAL**_____ I understand that the possible side effects for women on estrogen, progesterone, DHEA and/or testosterone include: breast swelling, and/or discomfort, fluid retention, dizziness, break through bleeding, acne, unwanted hair growth, headaches, breast cancer, increased risk of gallbladder disease, increased risk of clots, worsening of (1) ovarian cysts, (2) uterine fibroids, (3) endometriosis, and (4) fibrocystic disease.

INITIAL_____ I also understand that the use of thyroid hormone may cause a fast heart rate, an irregular heart rhythm, bone loss and or anxiety.

INITIAL_____ I also understand that the use of cortisol can cause weight gain, bone loss, cataracts, diabetes, fragile skin, high blood pressure, and or depression.

Men: □ **INITIAL**_____ I understand that the possible side effects for men on DHEA and/or testosterone replacement are acne, persistent erections, unwanted hair growth, enlargement of the prostate, enlargement of the breast tissue, and testicular atrophy (shrinking).

INITIAL_____ I also understand that the use of thyroid hormone may cause a fast heart rate, an irregular heart rhythm, bone loss and or anxiety.

INITIAL_____ I also understand that the use of cortisol can cause weight gain, bone loss, cataracts, diabetes, fragile skin, high blood pressure, and or depression.

Safety of Hormone Replacement

INITIAL_____ Although, in my physician's opinion, the majority of data points toward safety, there remains controversy regarding the correlation between the use of bioidentical hormone therapy and cancer. Recent data demonstrates that natural progesterone and estriol may be protective against breast cancer.

INITIAL_____ I understand that careful surveillance and close monitoring are requirements of all patients to minimize any possible risk.

INITIAL_____ I understand I may request copies of all relevant studies known to my physician, and that I may discuss them with my physician.

INITIAL_____ I also understand there are possible benefits associated with this therapy but that no guarantee has been made to be regarding outcomes of this treatment.

INITIAL_____ I also understand that the benefits derived from antioxidant therapy will cease and those derived from hormone therapy and drugs that alter hormone levels will reverse if the therapy is discontinued.

INITIAL_____ I also understand that if I am female and become pregnant, I should stop the entire treatment protocol immediately and notify my physician.

INITIAL_____ I understand that this hormone therapy is not for the purpose of preventing pregnancy, and that if I become pregnant on this therapy, it could present risk to the fetus (unborn child).

My Obligations and Representations

INITIAL_____ Any questions I have regarding this treatment have been answered to my satisfaction.

INITIAL_____ I understand that I will be responsible for administering the hormones prescribed to me. I will comply with the recommended dose and methods of administration.

INITIAL_____ I also agree to participate in the initial and subsequent hormone testing, as required to monitor my hormone levels.

INITIAL_____ I certify that I am under the regular care of another physician for all other medical conditions. I will consult my physician(s) for any other medical services I may require.

INITIAL_____ I understand that this is a specialized practice. I also understand that I will continue under the care of my other physician(s) for any on-going medical condition as well as for any medical consultation that I may need.

INITIAL_____ I assume full liability for any adverse effects that may result from the non-negligent administration of the proposed treatment.

INITIAL_____ I waive any claim in law or equity for redress of any grievance that I may have concerning or resulting from the therapy, except as that claim pertains to negligent administration of the therapy.

INITIAL_____ I fully understand the nature and purpose of portions of the aforementioned treatment may be considered experimental because of the lack of adequate scientific evidence or peer-reviewed publications supporting the underlying premise of bioidentical hormone replacement therapy and that such therapy might even be considered by some medical professionals to be medically unnecessary because it is not aimed at treating a particular disease.

INITIAL_____ I understand that I may suspend or terminate treatment at any time and hereby agree to immediately notify the physician of any such suspension or termination.

Consent

I hereby authorize my physician to evaluate and treat the conditions I specified above. I understand my physician may be assisted by other health professions, as necessary, and agree to their participation in my care as it relates to the evaluation and treatment of the conditions this Consent to Treat covers. I am competent to sign this Consent to Treat and have done so of my own free will.

Patient Name (please print) _____

Signature of Patient _____

Signature of Witness _____

Date _____

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