INCREDIBLE HEALTH
HEALTHY AND STRONG

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
- ☐ Other hormonal imbalance (specify): _____
- ☐ 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 Nature

The reasonable alternatives to this treatment have been explained to me and they include:

1. Leaving the hormone levels as they are.
2. Treating age related diseases as they appear.
3. Using pharmaceutical agents that are not bio-identical in nature.

Initial _____ I understand the foregoing alternatives and am choosing to consent to the treatment plan prepared for me to address the condition(s) indicated above. I understand that I may request a prescription for my pellet therapy in order to obtain my pellet/s from a pharmacy of my choice instead of at Incredible Health, LLC.

The General Nature and Extent of Treatment-Related Risks

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

Men: **Initial** _____ I understand that the possible side effects for men on testosterone replacement are acne, persistent erections, unwanted hair growth, enlargement of the prostate, enlargement of breast tissue, testicular atrophy (shrinking) and diminished, but not eliminated fertility.

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Safety of Hormone Replacement

Although, in my physician's opinion, the majority of data points toward safety, there remains and will continue to remain controversy regarding the correlation between the use of bio-identical hormone therapy, cancer and cardiovascular health. Recent data demonstrates that natural progesterone and estriol may be protective against breast cancer. There is also evidence that men with low testosterone levels have an increased rate of prostate cancer. I understand that it is possible to get cancer regardless of whether someone chooses to use bio-identical hormones or chooses not to use bio-identical hormones.

I understand that careful surveillance and close monitoring are requirements of all patients to minimize any possible risk. I understand I may request copies of all relevant studies known to my physician, and that I may discuss them with my physician.

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

I understand that bio-identical hormone therapy might change the fertility of male and female patients, either increasing or decreasing fertility. I understand that I will use contraceptive methods that do not rely on hormones (like a birth control pill does) to prevent any unintended pregnancies. I also understand that if I am female and become pregnant, I should stop the entire treatment protocol immediately and notify my physician. I understand that this hormone therapy is not for the purpose of preventing pregnancy (for men or women), and that if I become pregnant on the therapy it could present risk and harm to the fetus (unborn child).

Please circle the option that applies to you.

Abstinence Birth Control Pills Hysterectomy IUD Menopause Tubal Ligation

Vasectomy Other_____ Want to be fertile or trying to conceive

In addition, we ask that our patients continue with their screening exams as recommended.

_____ (Initials) I have had a normal Pap smear and mammogram or prostate exam/PSA within the past year or I am no longer medically required to have them. I will continue to get my annual exams.

_____(Initials) I have NOT had a Pap smear or mammogram or prostate exam/PSA within the last year. I voluntarily choose to undergo hormone replacement. I am aware that if any breast, uterine or prostate issues arise and/or develop while on hormone replacement, I release Dr. Harrison and Incredible Health, LLC from any liability should this occur.

My Obligations and Representations

Any questions I have regarding this treatment have been answered to my satisfaction. 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. I also agree to participate in the initial and subsequent hormone testing, as required to monitor my hormone levels or I will not be given refills on the hormone prescriptions.

I certify that I am under the regular care of another physician (primary care) for all other medical conditions, including mammograms and prostate exams. I will consult my physician(s) for any other medical services I may require. 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.

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

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 bio-identical 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. I also understand that bio-identical hormone therapy would be considered an off-label use.

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.

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of the **Notice of Privacy Practices** for Incredible Health, LLC which describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of the healthcare operations of Incredible Health, LLC. The Notice of Privacy Practices also describes my rights and Incredible Health, LLC's duties with respect to my protected health information. The Notice of Privacy Practices is posted in the patient portal of the electronic medical record, on the website at www.incredible-health.com or a paper copy will be provided to me upon request. Incredible Health, LLC reserves the right to change privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy to be sent by mail, asking for one at the time of my next visit to the clinic or accessing Incredible Health, LLC's website.

Consent

I hereby authorize my physican to evaluate and treat the conditions I specified above. I understand my physician may be assisted by other health professionals, 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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