Consent to Have Blood Drawn For Treatment/Testing

I authorize the medical staff at HerKare to obtain a blood sample for the purpose of determining specific laboratory test levels.

______________________________ ______________________
Patient Signature Date

Acknowledgement of Privacy Practices

Receipt of Notice of privacy practices acknowledgement: I have received or reviewed the privacy practice notice for HerKare, and understand the situations in which this practice may need to utilize or release my medical records.

______________________________ ______________________
Signature of Patient Date

Consent to Obtain Medication History

I authorize the HerKare to obtain my medication history from the e-prescribing network system. This information will be used by the providers of HerKare for the sole purpose of keeping a current and accurate listing of medications.

______________________________ ______________________
Patient Signature Date

WELCOME TO HERKARE!

Through our desire to provide you with the most focused and personalized healthcare experience, we would like to understand the primary reasons that have brought you to see us today. Please take a few moments to identify which of the following you are hoping to achieve through your experience at HerKare.

(Please assign a numerical value from 1-7 to each goal in order of importance.)

_____ Management of a Chronic Illness _____ Weight Loss _____ Improved Energy

_____ Physical Stamina & Endurance _____ Improved Mental Clarity

_____ Increased Libido _____ Improved Quality of Life

PATIENT INFORMATION

How did you hear about HerKare? ____ Last

Name: ________________ First Name: __________________ M Initial: _____ Mrs. Ms. Miss.

Preferred Name: ____

Address: ____

City/St/Zip: ____

SSN: ______________ Date of Birth: ___________ Age: _____ Height: _____ Weight: _____

Race & Ethnicity: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race

Preferred method of contact: ____

E-mail: ____

Home Phone: _______________________ Cell Phone: _____________________________

May we send you a text message reminder the day before your appointment? YES NO

Employer/Title:__________________________ Work Phone: _______________________

Work Address: _____________________________ City/St/Zip: ________________________

PRIMARY INSURANCE POLICY HOLDER INFORMATION (If different than yourself)

Last Name: ____________________ First Name: ___________________ M Initial: _______

Relationship: ___________________ Date of Birth: ____________ SSN: ________________

Preferred Phone: ________________ Employer: ___________________________________

Group / Policy #:____

EMERGENCY CONTACT INFORMATION

Name: ________________________ Relationship to Patient: _______________

Home Phone: ___________________ Cell Phone: _______________________

PRIMARY CARE / REGULAR PHYSICIAN

Name: ________________________ Phone: _________________________

New Patient

Name: ________________________________ **MRN**: ___________ **DOB:** _________________________________

Vital Signs: Age: ____ WEIGHT: _________LBS BP: _______/_______ HR: _____ RR: _____

Last Menstrual Period___________**Last Pap**___________ **Last Mammogram**____________ **Last Annual Exam**_________

HPI: ☐ Decline in libido ☐ Fatigue ☐ Decline in muscle mass ☐ Desires Fertility ☐ Prior HRT

Past Medical History: ☐ Negative ☐ High Blood Pressure ☐ High Cholesterol ☐Blood Clots ☐ Diabetes ☐ Asthma

☐ Cancer ☐ Sleep Apnea ☐ HIV/AIDS ☐Other____

Past Surgical History:

____

Pelvic Surgery: ☐ None ☐ Hysterectomy ___Partial ___ Total

Family History: ☐ Ovarian CA ______________ ☐ Breast CA _______________ ☐ Heart Disease _______________

☐ Diabetes_______________

Medications:

____

____

Allergies: ☐ NKDA ___________________

Other: ____
Metabolic: ____
Musculoskeletal: ____
Mental Function: ____

Sexual Function: ____

SHx: ☐ Tobacco _______ ☐ Alcohol _______ ☐ Illicit drug usage _______ ☐ Exercise _______ ☐ Caffeine _______

Marital Status: _____________________ **Occupation:** _______________________

PE Findings:

Assessment: ☐ Menopausal Syndrome ☐ Low Libido ☐ Depression ☐ Fatigue ☐ Insomnia

____

____

Plan: *Labs*: ☐ Full Panel ☐ PAP ☐ MRI ☐ Mammogram ☐ DEXA Scan

Medications: Testosterone: ☐ 15 mg IM q 10 days ☐ 20 mg q 10 days B12: ☐ 1000 mcg IM PRN

PATIENT HISTORY QUESTIONNAIRE (CIRCLE YES OR NO)

Yes No Have you ever had any muscle weakness, fatigue, or loss of muscle mass?

Yes No Has your interest in sex (libido) declined?

Yes No Do you feel depressed?

Yes No Have you felt an increased amount of stress?

Yes No Have you noticed abnormal weight gain in hips and/or waist?

Yes No Has your energy level or stamina declined?

Yes No Have you lost self-confidence, motivation, or initiative?

Yes No Has there been any decline in your memory or concentration ability?

Yes No Have you had sleep disturbances or problems breathing while sleeping?

Yes No Do you have any mood swings?

Yes No Have you noticed any increase in aggressiveness?

Yes No Do you have increased irritability?

Yes No Do you have any swelling in your extremities?

Yes No Do you have acne?

Yes No Are your nails breaking easily?

Yes No Have you noticed that your skin is thinning?

Yes No Do you have brittle, dry, or thinning hair?

Yes No Have you noticed any hair loss?

Yes No Have you noticed increased body or facial hair?

Yes No Do you have any breast tenderness or enlargement?

Yes No Have you taken birth control pills or Depo-Provera in the last year?

Yes No Are you pregnant?

Yes No Are you breastfeeding?

Yes No Have you ever had problems achieving pregnancy?

Yes No Are you considering having any (or more) children?

Yes No Have periodic hot-flashes or sweats at any time throughout the day?

Yes No Have you ever experienced any vaginal dryness?

Yes No Do you have anxiety or nervousness?

Yes No Have you ever had any emotional outbursts without reason?

Yes No Do you have difficulty getting a full night's sleep?

Yes No Do you have any constipation or abdominal bloating?

Yes No Do you experience tension headaches or migraines?

PAST HISTORY (CIRCLE YES OR NO)

Yes No Have you ever had an abnormal PAP or Mammogram?

Yes No Do you have any allergies to any medications? If yes, list on back of page.

Yes No Do you take any medications on a daily basis? If yes, list on back of page.

Yes No Do you have or have you ever had thyroid disease, diabetes, high blood pressure, asthma/lung disease, acne, dry or oily skin, or any venereal disease?

Please list the dates that you last had a: PAP: ____________ Mammogram: __________

FAMILY HISTORY (CIRCLE YES OR NO)

Yes No Do you have any blood related family members with breast cancer?

Yes No Do you have any blood related family members with ovarian cancer?

Yes No Do you have any blood related family members with diabetes?

Yes No Do you have any blood related family members with cardiovascular disease?

SOCIAL HISTORY (CIRCLE YES OR NO)

Yes No Do you use tobacco? If yes, how much? __________ How long? _______________

Yes No Do you drink alcoholic beverages? If yes, how much? __________

REVIEW OF SYSTEMS: PLEASE CHECK ANY THAT APPLY.

Ears, Nose, and Throat

__ Hearing Loss

__ Ringing in Ears

__ Altered Sense of Smell

__ Trouble Swallowing

__ Neck Pain/Stiffness

Lungs

__ Nonproductive Cough

__ Pain with Breathing at Rest

__ Pain with Breathing with Exertion

__ Pain with Inspiration

__ Wheezing

__ Coughing up Blood

__ Short of Breath with Exertion

Cardiovascular System

__ Chest Pain/Pressure at Rest

__ Chest Pain/Pressure with Exertion

__ Heart Palpitations

__ Normal Tolerance to Exercise

__ Pain in Legs with Walking

__ Cold Hands/Feet

__ Fainting

__ Lightheadedness

Integumentary (Skin) System

__ Rashes

Hematology (Blood)

__ Anemia

__ Hemochromatosis

Allergic

__ Hives

Neurological System

__ Headache

__ Loss of Sensation in any Body Part

__ Weakness of any extremity

__ Uncontrolled Muscle Movements

__ Dizziness

__ Problems with Walking

__ Speech Disturbance

Genitourinary System

__ Pain with Urination

__ Urinary Frequency

__ Urinary Urgency

__ Blood in Urine

__ Trouble Starting Stream

__ Difficulty Stopping Stream

Endocrine

__ Goiter (Lump in Neck)

__ Appetite Change

__ Heat or Cold Intolerance

Gastrointestinal System

__ Pain with Swallowing

__ Abdominal Pain

__ Nausea

__ Vomiting

Musculoskeletal System

__ Joint Pain (Any Joint)

__ Pain in any Muscles

__ Muscle Weakness

General Constitution

__ Fatigue

__ Night Sweats

__ Weight Loss

__ Weight Gain

Eyes

__ Headache

__ Blurry Vision

__ Double Vision

__ Visual Changes

Psyhiatric

__ Depressed

__ Anxious/Nervous

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Please select one of the following payment options:

Assignment of Benefits- Insurance

☐ I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), private insurance and any other health/medical plan to issue payment check(s) directly to HerKare Physicians Group PLLC for medical services rendered to me and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Insurance Waiver and Payment Agreement- Self Pay

☐ I have chosen to be self-pay for health care services provided by HerKare. I have decided to be self-pay even though I may have health insurance that covers these services and waive my right to have a claim submitted to my insurance company on my behalf. I agree to pay for services in the office on the date they are performed.

Authorization to Release Information

I hereby authorize HerKare Physicians Group PLLC to: (1) release any information necessary to insurance carriers regarding my illness and treatments: (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from HerKare on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

__________________________________ ______________________

Patient/Responsible Party Signature Date

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights - You have the right to:
· Get a copy of your paper or electronic medical record
· Correct your paper or electronic medical record
· Request confidential communication
· Ask us to limit the information we share
· Get a list of those with whom we've shared your information
· Get a copy of this privacy notice
· Choose someone to act for you
· File a complaint if you believe your privacy rights have been violated

Your Choices - You have some choices in the way that we use and share information as we:
·Provide disaster relief
·Provide mental health care
·Market our services
·Raise funds
·Tell family and friends about your condition

Our Uses and Disclosures - We may use and share your information as we:
·Treat you
·Run our organization
·Bill for your services
·Help with public health and safety issues
·Do research (where allowed by law)
·Respond to organ & tissue donation requests
·Respond to lawsuits and legal actions
·Comply with the law
·Work with a medical examiner or funeral director
·Address workers' compensation, law enforcement, and other government requests

Your Rights - When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you:
· You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
· We will provide a copy or a summary of your health information, usually within 15 days of your request. We may charge a reasonable, cost-based fee in states where such charges are provided for under law.
· You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
· You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
· You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
· If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
· You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months in states where such charges are provided for under law.
· You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
· If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
· You can complain if you feel we have violated your rights by contacting the Privacy Officer identified below. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices - For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to: (i) Share information with your family, close friends, or others involved in your care; or (ii) share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

We never sell your information, however when you give us written permission, we may use your information for marketing purposes. We will not attempt to re-identify de-identified protected health information without your permission. If you test positive for HIV, we will not release or cause to become known the positive result of such test without your permission, unless we are required to do so by law.

Our Uses and Disclosures - How do we typically use or share your health information?
· We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
· We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*
· We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*
· We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

· We can share health information about you for certain situations such as: Preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety
· We can use or share your information for health research, but only in states where that practice is allowed. In some states, we will ask your permission before using your information for health research.
· We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
· We can share health information about you with organ procurement organizations.
· We can share health information with a coroner, medical examiner, or funeral director when an individual dies. We can use or share health information about you: For workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, for special government functions such as military, national security, and presidential protective services.
· We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities – We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site at www.herkare.com/privacy.

Privacy Officer:
Any questions, concerns, or complaints may be directed to the Privacy Officer identified below:

Meghan Penny, Privacy Officer
1920 E. State Hwy 114
Southlake, Texas 76092
meghan.penny@herkare.com

Authorization for Release of Protected Health Information

FOR STAFF USE ONLY

Date of Request: _________ Number of Pages: ___________

The undersigned personally verified the capacity of the person requesting said records prior to the release of same.

Patient Charges: $________ Staff Initials: _______________

A SIGNED COPY OF THIS AUTHORIZATION MUST BE PROVIDED TO THE PATIENT OR THEIR AUTHORIZED REPRESENTATIVE

PATIENT NAME: ____ D/O/B: _________________

CHECK ONE:

______ I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information (''PHI'') described below to: **HerKare**

via Fax @ __________________________________ (45 CFR 164.530(c)) **OR**

______ I hereby authorize my healthcare providers at **HerKare** to release and/or disclose the protected health information (''PHI'') described below to:

Name: ____________________________________ Relationship: ___________________________

Purpose of Release: _______________________ by _____ Pick-up by _________________________

_____ Fax @___________________________

Other: ________________________________ _____ Email* @___________________________

(*not recommended)

****

2. Authorization for release of PHI covering (check one)

______ Last Labs Only

______ All records from (date) ________________ - to (date)______________________

______ All past, present and future periods.

3. I hereby authorize the release of the above PHI as follows (check one):

a. ____ my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse); OR

b. ____ my complete health record with the exception of the following information (check as appropriate):

_____ Mental health records
_____ Communicable diseases (including HIV and AIDS)
_____ Alcohol/drug abuse treatment

Other (please specify): ____ .

This authorization is valid until revoked by me in writing.

___________________________, OR _________________________________ ___________________

Patient Signature Authorized Patient Representative Signature Date

v1.1

Consent for Hormone Replacement Therapy

Patient Name: ____ MRN:_________________________ DOB: _________________________

It is important to HerKare that you understand the risks and benefits associated with Hormone Replacement Therapy (HRT) before beginning or continuing treatment. HRT is not a new area of medicine, however the treatment modalities employed by HerKare may involve innovative therapies and there are no guarantees with respect to the treatment prescribed. You should also be aware of alternatives to HRT, including not receiving HRT treatment, leaving hormone levels as they are, and treating age-related diseases as they appear. It is important that you consider the information we provide and discuss the information carefully with your Provider. Be sure that you are doing what is right for you. If you are unsure, then you should refuse and/or discontinue treatment. Many women suffer from symptoms associated with inadequate hormone levels. These symptoms are often related to menopause or aging. Such symptoms may include inability to lose weight, vision loss due to macular degeneration, sleep difficulties, increased hot flashes, night sweats, decreased cognitive function, decreased libido, fatigue, or anxiety, and bone loss. These symptoms may be treatable utilizing hormones. The therapeutic objective of HRT is to optimize hormone levels, helping to reduce symptoms. HRT is considered by some insurance providers as a form of alternative medicine. This means that some treatment options at HerKare may not be covered by your specific health insurance (different health insurers have different definitions in their policy documents). You will be required to separately pay for these services at the time they are rendered if your insurance does not cover them.

The hormones that may be prescribed as part of treatment may include Estrogen, Progesterone, and Testosterone, as well as other treatments for thyroid function, and Vitamins D and B12, where indicated. Recommended treatment in some instances may include “off-label" drug use of FDA-approved medications such as Testosterone. Off-label use means use of FDA-approved medications for additional indications, where determined to be appropriate by the treating physician. Currently, testosterone is only FDA-approved for use in men. If your treatment includes testosterone, your Provider must review the information on the following page with you before you commence treatment. Ask any questions that you may have, and be certain before commencing treatment. There are a number of potential side effects related to HRT. You should discuss each of these with your Provider. Side effects may include bloating, breakthrough bleeding, breast swelling and tenderness, clitoral enlargement, fluid retention, weight gain, liver cysts, mood swings, increased red blood cells, acne, hair growth, vocal changes, sleep apnea, or heightened cholesterol levels. In some patients there could be increased risks of endometrial, uterine, or breast cancer, blood clots, stroke, gallbladder disease, or high blood pressure. Certain types of HRT have a higher risk, and each woman's own risks can vary depending upon her health history and lifestyle. It is important that you provide an accurate and complete medical history to your Provider. Please tell your Provider if you have used alcohol or illicit drugs prior to your treatment visit. You can learn more about potential side effects associated with each hormone at www.herkare.com, or www.medwatch.com. You and your Provider need to discuss the risks and benefits of treatment. You should not participate in HRT if you are, or are thinking of, becoming pregnant. You should not participate in HRT if you are at risk for becoming pregnant (premenopausal or not currently taking birth control) without specifically discussing the risks involved with your Provider. You should not participate in HRT if you have, or have been treated for, certain types of cancer.

Patient's Initials:

"This is my consent for HerKare, including any physician, health care provider or nurse who works with the HerKare physicians, to begin treatment for Hormone Replacement Therapy.

______ I have read and understand, that there may be complications arising from or related to treatment as described above, and explained by my treating medical provider. I have had an opportunity to discuss my complete past medical and health history including any serious problems and/or injuries, as well as my family history of diseases and conditions, with my Provider. All of my questions concerning the risks, benefits, and alternatives to treatment have been answered. I am satisfied with the answers and desire to commence treatment, knowing the risks and potential side effects involved.

______ I understand that I will have periodic blood tests to monitor my blood levels of each hormone and I consent to such testing. I understand that the physical exam by HerKare does NOT replace a full physical exam by my personal physician, and I agree to have my personal physician (not HerKare) perform a full physical exam including a lipid profile, cholesterol profile, mammogram, pap smear and full metabolic panel, not less than annually.

______ I understand that each patient is different and there are no guarantees as to results obtainable from HRT treatment. HRT is not a cure, and if I stop treatment, symptoms may return or worsen.

______ I am not pregnant, and am not planning on becoming pregnant, and am not at risk of becoming pregnant. I do not have and have not been diagnosed with cancer.

______ Prices for treatment have been fully explained to me and if my insurance does not cover treatment, I will be charged the current price for the therapeutic options I choose."

____ _____________________
Patient Signature Date

"I have reviewed each of the foregoing with the patient, including discussing the potential risks and benefits of treatment, the patient's complete past medical and health history and relevant family medical history. The patient has been provided the opportunity to ask questions concerning the risks, benefits, and alternatives to treatment, and desires to {Circle one} commence / refuse treatment. The patient has reported that she is not at risk of becoming pregnant."

____ _____________________
Provider Date

Additional information: Low-Dose Testosterone Therapy

Patient Name: ____ MRN:_________________________ DOB: _________________________

Many patients, in conjunction with their physician's advice, choose to supplement their care with low-dose testosterone therapy. It is important to HerKare that you understand the purpose, risks and benefits associated with testosterone therapy before making it a part of your treatment. Testosterone therapy is a treatment that may be used to raise a woman's sexual interest, muscle mass, or physical function. Testosterone therapy is sometimes used for women who are on estrogen therapy, have had their ovaries removed, or suffer from an adrenal system problem, or hypopituitarism. It is associated with the relief of symptoms of menopause (hot flashes, vaginal dryness, incontinence and urinary urgency), and may enhance mental clarity and focus. Testosterone therapy has been shown in some instances to increase bone density, decrease body fat and cellulite, and increase lean muscle mass. Some studies associate testosterone therapy with reduced cardiac risk, and breast-protection, particularly for patients on estrogen therapy.

When a drug is approved for medical use by the Food and Drug Administration (FDA), the manufacturer produces a “label” to explain its use. Once a medication is approved by the FDA, physicians may use it “off-label” for other purposes if they are well-informed about the product, base its use on firm scientific principles and sound medical evidence, and maintain records of its use and effects. Testosterone is approved by the FDA only for use in men. This means that physician directed low-dose testosterone therapy in women is "off-label." **Because testosterone therapy is "off label" your health insurance may not provide coverage for testosterone therapy. This means that you will be required to pay for these services at the time they are rendered.** For patients who have access to a Health Savings Account (HSA), you may ordinarily choose to use the HSA to pay for treatment.

After reviewing your case, your Provider will fully discuss whether low-dose testosterone therapy is an option appropriate for consideration. There is no requirement that you include testosterone in your therapy at HerKare. Of course, before commencing any therapy, you should be aware of the associated risks and contraindications for treatment. Because testosterone therapy in women is considered off-label, all the possible side effects and potential complications may not be known. In general, you should not take testosterone if you are or could become pregnant, if you have or have had breast or uterine cancer, or if you have high cholesterol, heart or liver disease. Side effects associated with testosterone use could include increased risk for acne, inappropriate hair growth, or deepening of the voice. If you notice any of these changes, talk to your Provider, as these side effects may be managed by lowering the dose or discontinuing treatment.

Patient’s Initials

_____ I understand that this is an off label use of the hormone testosterone, therefore no one can be fully aware of all possible side effects and complications.

_____ The details of this treatment including anticipated benefits, material risks and disadvantages have been explained to me in terms I understand.

_____ My Provider has covered alternative treatments, prescriptions and therapies, their benefits, material risks and disadvantages and these have been explained to me in terms I understand.

_____ I understand that no guarantees about the results of any therapy at HerKare have been made. My Provider has answered all of my questions and I desire to commence treatment.

____ ____________________

Patient Signature Date

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed therapy for the patient. I have answered all questions fully, and I believe that the patient fully understands what I have explained.

____ ____________________

Provider Date