APOLLO
MEDICAL ASSOCIATES

Bio-Identical Hormone Therapy Waiver

The Apollo Medical Associates, Bio-identical Hormone program and its providers follow guidelines set forth by the FDA and the National Institute of Health. While numerous safety measures are taken by our staff, incidental events may occur that are beyond the control of our staff. Within the medical community, there are opposing views with respect to the use of bio-identical hormone replacement therapies. The use of bioidentical hormones does provide true medical benefit, and it is being used at our office to lessen/treat symptoms you have identified as bothersome.

It is therefore expressly agreed that you are voluntarily participating in this program with the bio-identical hormone replacement regimen, and the use of any medication and/or supplements is undertaken at your own risk. You are voluntarily participating in this program and assume all the risks of injury to yourself that might result. You hereby agree to waive any claims or rights you might otherwise have to pursue legal remedies from Apollo Medical Associates, its staff, or treating providers for injury to you on account of involvement in the Bio-identical Hormone Replacement program.

I have carefully read this waiver and fully understand that it is a release of liability.

I accept all terms and conditions as stated herein.

_____ _____
Signature **Date**

_____ _____
Print Name **Date**

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Patient Consent to Treatment

I hereby give my consent to treatment intended to enhance quality of life by improving health, vigor, and vitality through the administration of hormone replacement therapy and/or nutritional supplements, including vitamins, minerals and antioxidants and/or drugs designed to alter hormone levels. The nature of the therapy is to augment levels of hormones in my body to levels in the upper 33% of the normal range for a patient's age. The exceptions are insulin and cortisol that should be modulated to the lower 33% of the normal range. Regarding supplements, the goal is to raise levels of vitamins, minerals, and antioxidants in order to maximize the physiologic processes in the body and minimize damage by naturally produced free radicals.

Alterative Treatment Approach:

The reasonable alternatives to these therapies have been explained to me and they include:

Leaving hormones at current levels
Treating age related diseases as they occur
Self-medication

Potential Risk of Therapy:

I am aware that there are certain risks associated with these therapies, which may occur in up to 10% of the population. These risks include water retention, which may result in leg swelling, elevated blood pressure, mild increase in fasting blood sugar, and occasional bruises at the injection site. I may also develop infection at the injection site if I use improper techniques. Other possible side effects include breast swelling and/or discomfort for women and testicular atrophy (shrinking) for men. All of these side effects are reversible by dosage adjustment or stopping therapy. There is the possibility of testosterone or estrogen therapy causing blood clots (DVT), stroke, pulmonary embolus, and cardiovascular events such as heart attacks. Our office does not believe the literature supports these possibilities, but these risks are stated in the PDR and by the FDA.

I understand these risks and am comfortable utilizing testosterone therapy if indicated or desired.

I understand that careful surveillance and close monitoring of the prostate with Digital Rectal Exams and PSA levels are required of all male patients.

I also understand there are benefits associated with these therapies that have been outlined in literature I have received from my physician that I acknowledge I have read. I understand that no guarantee has been made to me regarding the outcome 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 once the therapy is discontinued.

I understand that if I am female and become pregnant, I should stop the entire program immediately and notify my physician. I also understand that this hormone therapy is not for preventing pregnancy, and that if I become pregnant on this therapy it could present risks to my fetus (unborn child).

I also understand I may request copies of all relevant studies regarding risks and benefits of hormonal augmentation known to my physician, and that I may discuss them with my physician.

Other Matters:

I understand that I may be responsible for injecting and administering the hormone prescribed to me. I will conform and comply with the recommended dose and methods of administration. I also agree to conform to the request for initial and subsequent blood tests, as required to monitor my hormone levels.

I authorize Apollo Medical Associates and their providers to perform this treatment. I understand they will be assisted by other health professionals, as necessary, and agree to their participation in my care as it relates to nutrition, exercise, nutrient supplementation, and hormone modulation therapy. 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. I understand that I will continue under the care of my other physician(s) for any on-going medical conditions as well as for any medical consultation that I may need.

I assume 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 procedure, except as that claim pertains to negligent administration of the procedure.

I hereby confirm that the nature and purpose of the aforementioned treatment is considered by some to be medically unnecessary and/or experimental because they are not aimed at treating a disease, and there are no long-term studies documenting the results. The risks involved and the possibilities of complications have been explained to me. I fully understand that the treatment to be provided may be considered experimental and unproven by scientific testing and peer-reviewed publication.

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

If your provider prescribes growth hormone, he or she will do so only if you are diagnosed with “adult deficiency" for growth hormone. Please be advised that Apollo Medical Associates ICD-10 codes are for classification only and cannot be used for insurance reimbursement.

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To attest to my consent to this treatment, I hereby affix my signature to this authorization to treatment.

_____

Patient Name

_____

Signature of Patient **Date**

_____

Signature of Provider **Date**