BIOGENICS MD

Consent for Hormone Supplementation Therapy

_____I consent to the administration of hormones and oral supplements as prescribed by the Physicians of Biogenics MD. I acknowledge that there are no guarantees or assurances made with respect to the benefit of hormone therapy, and as with any medication. there is a risk of unintended side effects.

_____I understand that I will be in charge of the administering hormones and supplements prescribed to me. I will conform and comply with the recommended doses and methods of administration.

_____I understand that initial blood tests will be performed to establish my baseline hormone levels. I agree to comply with the requests for ongoing tests to assure proper monitoring of my hormone levels. I agree to report to the physician any adverse reaction or problems that might be related to hormone therapy. I understand that with hormone supplementation there are possible risks and complications if I do not comply with the recommended dosage.

_____I have not been promised or guaranteed any specific benefit from the administration of this therapy. I understand the hormone supplementation for rejuvenation purposes is a new specialty and there are no guarantees with respect to the treatment prescribed.

_____I understand that the role of the physician is for hormone replacement only. I agree that I am and will be under the care of another physician for all their medical conditions.

_____I have been informed that the insurance carriers and Medicare do not pay for hormone therapy. I therefore agree to pay for all services including laboratory and pharmacy charges, with the understanding that I will not be reimbursed by my insurance company.

_____ I have read and understand the above consent. I fully understand what I am signing and hereby request and consent to treatment using hormone therapy supplementation.

Patient Signature_____ Date_____

Physician Signature_____ Date_____