Informed Consent to Treat

I hereby give my consent to evaluation and treatment by Eternal Health, Ida Redican NP, and any other provider associated with Eternal Health for the following specified condition(s):

☐ Andropause or associated symptoms (Including testosterone replacement, manipulating hormone levels including DHEA and estradiol).

☐ Growth hormone abnormalities including decreased or suboptimal IGF -1, decreased or suboptimal Vitamin D-3 levels.

☐ Nutritional deficiencies, Overweight/Obesity, B12 injections and anything else the medical provider deems is necessary.

In addition:

☐ I acknowledge that treatment with testosterone, growth hormone stimulators, bioidentical hormone replacement therapy, B12, and thyroid optimization are considered off label use of the associated medications and have not been FDA approved for the use of health optimization, wellness, weight loss and/or for anti-aging purposes unless there is true medical necessity.

I agree to the administration of hormone replacement therapy, and/or nutritional supplements, and/or drugs designed to alter hormone levels which will meet my specific treatment objectives and to treat any specific diagnoses I might have.

Signature:_____Date_____

Alternative Treatments

I have been informed about alternative treatments and understand:

1. That we can leave the hormone levels alone.
2. We can use a natural approach such as weight loss and nutrition instead.
3. We can use alternative medications to increase your testosterone levels vs using prescription testosterone.

☐ I understand the alternative treatments and am choosing to consent to the treatment plan prepared for me by (LLC NAME) to address the condition/conditions listed above.

Signature:_____Date_____

Side Effects and Potential Risks

☐ I acknowledge that common side effects of testosterone replacement are acne, possible balding, enlargement of the prostate, high blood pressure, high libido, enlargement of breast tissue (we will monitor and treat estrogen levels), testicular atrophy, fluid retention, infertility, and an increase in the thickness of your blood (hematocrit) due to the production of red blood cells (this will be monitored and treated if necessary).

☐ I understand that the possible theoretical/possible side effects for men on testosterone replacement can be an acceleration in the growth of prostate cancer, elevations in hematocrit which could potentially predispose one to a blood clot, and cardiovascular disease including heart attacks, strokes, and blood clots.

Most of the common side effects resolve with time. Many of these can be treated by changing your testosterone dose and adding other medications.

I acknowledge that I should take extreme precaution if I am to use topical testosterone products. If a child or women accidently is exposed to the testosterone cream/lotion on my body it could cause a significant increase in their hormone levels which could result in possible side effects.

Signature:_____Date_____

Safety of Hormone Replacement

Available data supports the safety of testosterone replacement therapy in men, and it is of the opinion of (LLC NAME) and/or (PROVIDERS NAME) that treatment is safe, but there still remains controversy regarding the correlation between the use of testosterone replacement therapy and cardiovascular events such as but not limited to: strokes, heart attacks, and blood clots. Some studies have shown correlations between testosterone replacement therapy and cardiovascular disease while others show no correlation or even a benefit in preventing cardiovascular disease.

☐ I understand that close monitoring is required by all patients to minimize and prevent any possible risks. I understand that (LLC NAME) will monitor my blood work including hormone levels. I also understand that it is important to stay up to date with routine screening and health maintenance by my primary care provider to prevent and detect any possible life threatening diseases or conditions.

☐ I agree to obtain and remain up to date on all age-appropriate screenings including, but not limited to, digital rectal exams, colonoscopies, cardiac screenings, and any other type of recommended health screenings. I agree to obtain these screenings through the direction of my primary care provider and will not hold (LLC NAME), (PROVIDER NAME) NP, or any additional (LLC NAME) staff responsible or liable for performing these health maintenance screenings or the treatment of any other conditions not relevant to my treatment goals with (LLC NAME).

☐ I want to initiate treatment at (LLC NAME) and I give permission to (LLC NAME) and (PROVIDER NAME) NP and additional staff of (LLC NAME) to begin treatment without knowing results of age-appropriate and health maintenance screenings. In doing so, I release (LLC NAME), (PROVIDER NAME) NP and other healthcare practitioners of any claims of liability for cardiovascular events, prostate cancer, breast cancer, testicular cancer, and/or colon cancer. Further, I agree to immediately notify (LLC NAME), (PROVIDER NAME) NP and additional staff of (LLC NAME) of any abnormal findings on any health screenings done by my primary care provider.

Signature:_____Date_____

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 and/or medications prescribed to me if I do not have them administered to me in clinic. I also promise to comply with the dosages and frequency of medications prescribed to me.

I certify that I am under the regular care of a primary care provider or a specialist for any other conditions I might have or am found to have. I will consult with my primary care provider or specialist in regards to any other condition I might have. I understand that if I do not have a primary care provider, that I will be encouraged to seek one out. I acknowledge that I am seeking care at (LLC NAME) for the specific services (LLC NAME) offers. I acknowledge I am not wanting to establish primary care with (LLC NAME) and I am here for specialized care including testosterone replacement, hormone restoration, etc.

I have reviewed the mentioned risks and have determined the benefits outweigh the possible risks associated with hormone restoration and treatment with (LLC NAME). I release any claim in court or any type of complaint that could result from treatment with (LLC NAME), (PROVIDER NAME) and any other staff associated with (LLC NAME) and will not hold liable any provider or staff of (LLC NAME).

I understand that treatment modalities utilized by (LLC NAME) might not be supported by scientific/medical literature and could be seen as experimental or based off anecdotal claims. Many medical providers, including endocrinologists and urologists, might see these types of treatments and not medically necessary.

Signature:_____Date_____

Consent

I hereby authorize (LLC NAME), (PROVIDER NAME) NP and additional staff of (LLC NAME) to evaluate and treat conditions that I have consented for. I consent to obtaining blood work before my initial evaluation so hormone levels can be monitored and appropriate treatment can be prescribed. I certify that I am signing this under my free will and am competent to make my own medical decisions.

Print Name:_____

Signature:_____Date_____

Indemnification Clause

I, _____, agree to indemnify, defend, protect, and hold harmless (PROVIDER NAME)P, medical providers employed by (LLC NAME) and (LLC NAME) LLC; and their respective officers, directors, employees, stockholders, assigns, successors and affiliates (Indemnified Parties) from, against and in respect of all liabilities, losses, claims, damages, judgements, settlement payments, deficiencies, penalties, fines, interest and costs, expenses suffered, sustained, incurred or paid by the indemnified parties, in connection with, results from or arising out of, directly or indirectly, (PROVIDER NAME), NP, medical providers employed by (LLC NAME) and (LLC NAME) LLC; rendering medical care, services, advice, and/or treatment, my failure to disclose all relevant information regarding my medical and physical condition, acts or omissions, of (PROVIDER NAME), NP, (LLC NAME), LLC; harm or injury resulting from medical care or pharmaceuticals provided directly or indirectly by (PROVIDER NAME), NP or (LLC NAME) LLC. I am aware of the potential side effects associated with the above treatments, accept all the risks involved in taking the medication and will not seek indemnification or damages from the indemnified parties.

Printed Name:_____

Signature:_____Date:_____

Witness:_____Date:_____