Optima
Medical Hormone Replacement
& Aesthetic Center

Consent for Bio-identical Hormone Replacement Therapy

I request and consent to the administration of bio-identical hormones and oral supplements and authorize that these will be prescribed by the nurse practitioner. I understand that treatment with estradiol is FDA approved for menopausal symptoms, progesterone is FDA approved for endometrial hyperplasia, and testosterone is FDA approved for hypogonadism. I acknowledge that estradiol, progesterone and testosterone may be prescribed off label for a variety of other reasons and symptoms. I acknowledge that there are no guarantees or assurances made with respect to the benefit of the bio-identical hormone supplementation therapy prescribed for me.

I understand that I will be in charge of administering these 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 requests for ongoing testing to assure proper monitoring of my hormone levels. I agree to report to the nurse practitioner any adverse reaction or problems that might be related to my hormone therapy. I understand that with hormone supplementation there are possible risks and complications if I do not comply with the recommended dosage. I understand that with testosterone administration some studies have shown an association of increased risk of heart attack or stroke. After consideration of these risks I consent to treatment with hormones.

I have not been promised or guaranteed any specific benefit from the administration of this therapy.

I understand that the role of the nurse practitioner is for bio-identical hormone replacement only. I agree that I am and will be under the care of another physician for all other medical conditions.

I have been informed that insurance companies and Medicare do not pay for bio-identical hormone supplementation therapy. I therefore agree to pay for all services including laboratory and pharmacy charges myself, with the understanding that I will not be reimbursed by my insurance company. There are no exceptions.

I have read and understand all of the above consent. I have had other information given to me about bio-identical hormone supplementation therapy so that I fully understand what I am signing and hereby request and consent to treatment using bio-identical hormone supplementation therapy.

Signature _____ Date _____

Provider Signature_____ Date_____