

Consent for Hormone Supplementation Therapy

I, _____ specifically authorize Dr. Kristen Steely, D.C., to perform an evaluation and develop for me a suggested plan for optimal health. I warrant that all information that I have submitted for my evaluation is true to the best of my knowledge.

I request and consent to the administration of bioidentical hormones and oral supplements and authorize that these will be recommended based on results from saliva tests evaluated by BioHealth Laboratories. I understand that my test results will be analyzed by a BioHealth Lab physician and discussed with Dr. Steely.

I understand that initial blood and/or saliva tests will be performed to establish my baseline hormone levels. I agree to comply with reasonable requests for follow-up testing to assure proper monitoring of my hormone levels. I agree to report to the doctor any adverse reaction or problems that might be related to my hormone therapy.

I understand that with hormone supplementation that there are possible risks and complications if I do not comply with recommended dosages. I understand that I will be in charge of administering the hormones and supplements prescribed to me. I also acknowledge that there are no guarantees or promises made with respect to how well I will benefit from the hormone supplementation therapy prescribed for me. I understand that I will need to follow up with Dr. Steely as she prescribes in order for me to continue to purchase supplements for the treatment of my hormone imbalance.

I will conform and comply with the recommended dosages and methods of administration. I understand that the role of Dr. Steely is for the management of my preventive anti-aging health plan and hormone replacement only. I agree that I will be under the care of another health care provider for all other medical conditions. I agree that Dr. Steely will not take the place of my personal medical provider in this regard. I acknowledge that Dr. Steely has in no way told me to discontinue the use of any medications prescribed to me by my personal medical provider(s).

I have been informed that insurance companies and Medicare do not pay for 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 for laboratory and pharmacy charges.

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

Patient Signature _____

Date _____

Physician Signature _____

Date _____