

FEMME CLINIQUE INFORMED FEMALE PATIENT CONSENT HORMONE THERAPIES

Please read and sign the following informed consent agreement:

Your visit includes a private examination with a licensed physician. Your doctor will talk to you about your medical condition and perform any physical examples or lab tests medically indicated and agreed upon by you for the chief concern that brought you to the clinic.

I UNDERSTAND THAT BLOOD TESTS AND MEDICAL HISTORY WILL BE USED TO ESTABLISH MY BASELINE HORMONE STATUS. I AGREE TO FOLLOW ALL RESONABLE REQUESTS FOR ONGOING LAB TESTING TO ENABLE FEMME CLINIQUE PHYSICIANS TO TREAT ME EFFECTIVELY. IN ADDITION, I WILL REPORT ANY POTENTIAL ADVERSE REACTIONS OR CHANGES IN MY MEDICATIONS OR DOSING TO FEMME CLINIQUE SO THEY CAN HELP ME OPTIMIZE MY TREATMENT BENEFITS AND PREVENT ANY SIDE-EFFECTS AND AS WITH ANY THERAPY I UNDERSTAND THERE ARE POTENTIAL SIDE EFFECTS ATHOUGH THEY TEND TO BE MINIMAL. POTENTIAL SIDE EFFECTS INCLUDE MOOD CHANGES, ACNE, HAIR LOSS/GROWTH, BREAST TENDERNESS, AND ABNORMAL MENSES. I UNDERSTAD THAT MY TREATMENT IS DESIGNED TO MINIMIZE ANY OF THESE SIDE EFFECTS AND INCREASE BENEFITS OF THE THERAPY. I AGREE TO COMPLY WITH THE RECOMMENDED DOSES TO HELP PREVENT ANY COMPLICATIONS.

I UNDERSTAND THAT I WILL BE IN CHARGE OF ADMINISTERING MY HORMONES AND SUPPLEMENTS AS PART OF MY TREATMENT AND I UNDERSTAND FEMME CLINIQUE CANNOT BE HELD RESPONSIBLE FOR MY MISUSE OF ANY MEDICATIONS. I UNDERSTAND THAT FEMME CLINIQUE IS MANAGING ONLY MY CARE IN RESPECT TO HORMONE THERAPY AND AGREE TO HAVE A PRIMARY CARE PROVIDER FOR OTHER HEALTH ISSUES UNLESS OTHERWISE EXPLICITLY AGREED UPON BY BOTH PARTIES. I UNDERSTAND THAT FEMME CLINIQUE WILL BE AN ADDITION TO MY MEDICAL CARE BUT NOT A REPLACEMENT FOR MY PRIMARY MEDICAL PROVIDER. I AGREE TO RECEIVE YEARLY MAMMOGRAMS AND PAP SMEARS AND REPORT ANY ABNORMAL RESULTS TO MY PHYSICIAN AT FEMME CLINIQUE.

I UNDERSTAND THAT I HAVE THE RIGHT TO CHOOSE ANY PHARMACY FOR FILLING MY PRESCTION FROM FEMME CLINIQUE.

If you have read the above statements and understand them, please sign and date:

Patient Signature: _____ Date: _____