GRAMERCY PARK INTEGRATIVE
DR. DLADLA

TESTOSTERONE THERAPY CONSENT

Select one:

_____ My physician has recommended testosterone therapy for me based on a testosterone deficiency determined by clinical symptoms/signs and serum laboratory analysis.

_____ My physician has recommended a trial of testosterone therapy for me based on a testosterone deficiency determined by clinical symptoms/signs, including the ADAM Questionnaire, despite normal serum laboratory analysis. However, some patients with laboratory analysis indicating testosterone levels on the low end of normal range combined with symptoms experience symptomatic improvement with therapy.

Nature of Therapy

Testosterone Replacement Therapy is often prescribed to men during andropause (lower levels of male hormones) for symptoms of lethargy or decreased energy, decreased libido or interest in sex, erectile dysfunction with loss of erections or decreased strength of erections, muscle weakness and aches, inability to sleep, night sweats, depression, loss of height, decreased strength and endurance, and thinning of bones.

A testosterone prescription may be given by injection, transdermal cream or lozenge. Risks of testosterone replacement include, but are not limited to: stimulation of benign and malignant prostate tumor. Testosterone replacement is contra-indicated in patients with known prostate cancer.

The most common immediate side effects (occurring in approximately no more than 6% of users) include, but are not limited to: acne, application site reaction, headache, hypertension (high blood pressure), abnormal liver function tests, and non-cancerous prostate disorder. Other possible side effects include: male pattern baldness, gynecomastia (breast enlargement), diminished sperm production, a reduction in the size of the testicles, greasy hair and skin, a strong body odor, and aggressiveness.

Testosterone replacement may lead to an increase in the red blood cells, determined by periodic measuring of blood work. It is not a common occurrence and generally poses no health risk; if timely and appropriately identified, it can generally be corrected by donating blood or with a therapeutic phlebotomy. Testosterone replacement may reduce insulin requirements in insulin-dependent diabetics. Older male patients may be at a slightly increased risk for the development of prostate enlargement when replacing testosterone. The concurrent use of testosterone with corticosteroids may enhance edema (fluid retention) formation. Edema may be a complication with testosterone replacement in patients with pre-existing cardiac, renal, or hepatic disease. It is not known whether testosterone replacement therapy will increase the risk for prostate cancer.

Testosterone applied topically to the skin may cause transference to others and result in hair growth at the application site.

Consent to Therapy:

In consideration of the care and treatment to be provided to me by <Practice or Physician name>, the undersigned consents to and agrees to the following conditions:

1. **Consent to Treatment**: I have discussed the reasons for undergoing Testosterone Replacement Therapy with my doctor and understand why he is prescribing it. I understand and have discussed the risks and potential side effects of Testosterone Replacement Therapy with my doctor or clinician. I understand and accept these risks, and I wish to proceed with Testosterone Replacement Therapy. I understand that in order to continue treatment and monitor my care, regular office visits and repeat blood work may be required. I understand that I do not have to undergo this treatment and that I may decide to discontinue it at any time. I have been told how to use this medication or treatment in such a way that I fully understand. I have been informed that if any supplements have been recommended by my physician I may purchase them wherever and from whomever I prefer and that I may choose whether or not to take them. Based upon the foregoing, I voluntarily consent to Testosterone Replacement Therapy to be provided by <Practice or Physician name> and its associated physicians, clinicians, and other personnel. I agree that I will follow all recommendations concerning the use of testosterone, including, but not necessarily limited to, lab tests and appointments at regular intervals. I agree to take Testosterone Replacement Therapy as directed.

2. **Results not guaranteed.** I am aware that the practice of medicine and other health care professions is not an exact science and I further understand and acknowledge that no guarantee has been or can be made as to the results of the treatments or examinations by <Practice or Physician name>, including, but not limited to, the results of Testosterone Replacement Therapy.

3. **Use and Disclosure of Protected Health Information**: I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, for treatment, and for health care operations.

4. **Prior Authorization**: I understand that many insurance companies or other payers require pre-authorization or referrals for certain treatment, tests and /or procedures. I understand that it is my/the patient's responsibility to obtain either pre-authorization or referral. I understand that I may be held financially responsible for treatment, tests and/or procedures that are not reimbursed by my/the patient's insurance company or other payer due to lack of pre-authorization and/or referral, or as a result of the service/treatment not being a covered service, as stipulated in my/the patient's particular insurance policy.

Guarantee of Payment

By signing the form below, I understand and acknowledge that:

1. I am financially responsible for this account with, and for the fees associated with services I receive from, <Practice or Physician name>, regardless of any insurance benefits, to the fullest extent allowed by law.

2. I understand that I may be held responsible for any charges not covered for any reason by a third party payer. Should this account be turned over to a collection agency or an attorney for collection, I understand that I will be obligated to pay all collection fees and reasonable attorney's fees.

By signature below, I consent to and agree to the conditions set forth on this form. I have been given the opportunity to ask questions regarding this form, and understand the obligation I assume by signing this form.

Signature: _____

Printed Name: _____

Date: _____

Witness Signature: _____

Printed Name: _____