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 will conform and comply with the recommended dosages and methods of administration. I understand that in order for Dr. Steely to manage my hormone imbalance, I need to aquire the bioidentical hormones through Dr. Steely. If I choose to purchase my hormones through another source, the results may be undesired. I understand purchasing supplements from another source has no guarantee on the potency or the effectiveness of the product.
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 or 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.
If said patient chooses to not follow the prescribed plan as requested, Dr. Steely can and will refuse further treatment, and will release patient from care.

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 _____