Lemon-AID
Medical Management

DISCLOSURE AND CONSENT FOR HORMONE TREATMENT

TO THE PATIENT: You have the right as a patient to be informed about your condition and the recommended surgical, medical, or diagnostic procedures to be used so that you may decide whether to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to better inform you so you may give or withhold your consent to the procedure.

I _____voluntarily request providers, medical assistants, and other healthcare workers at Lemon-AID Medical Management as they deem necessary to treat my conditions, which has been explained to me as

Condition(s) to be treated (check all that apply):

_____ Menopause/perimenopause
_____ Andropause / male hypogonadism
_____ Hypothyroidism
_____ Hyperthyroidism
_____ Other thyroid disease
_____ Low testosterone
_____ Estrogen/progesterone imbalance
_____ Sexual dysfunction / low libido
_____ Adrenal dysfunction
_____ Insulin resistance/prediabetes
_____ Polycystic ovary syndrome (PCOS)
_____ Vitamin or nutrient deficiency
_____ Growth hormone deficiency
_____ Pituitary disorder
_____ Weight management / metabolic health
_____ Other: _____

I understand that the following surgical, medical, and/or diagnostic procedures are planned for me, and I voluntarily consent and authorize them: lab work, medications, hormone replacement, and education.

I understand that my provider may discover other conditions that require additional or different procedures than those planned. I authorize the providers at Lemon-AID Medical Management to perform other procedures as advisable in their professional judgment.

My consent extends to all hormones and other medications prescribed or administered to me by Lemon-AID Medical Management in connection with this treatment, including the specific agents, doses, strengths, routes of administration, and formulations selected by my provider, whether commercially manufactured or compounded, and including any brand or generic equivalent. I understand my provider may start, stop, substitute, or adjust any medication or dose over the course of my treatment based on my response, my lab results, and their professional judgment, and I consent in advance to those changes without needing a new written consent. I understand that some medications or uses may not be FDA-approved for hormone treatment and may be prescribed off-label, and I consent to their use. I understand I will have the opportunity to discuss any medication or change with my provider before it is prescribed, and that I may decline any medication at any time.

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I understand that no warranty or guarantee regarding results, improvement, or cures has been made to me by any provider or staff member, and that no such assurance should be inferred from any discussion, written material, or advertisement.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the surgical, medical, and/or diagnostic procedures planned for me. I realize that surgical, medical, and/or diagnostic procedures include but are not limited to the potential for infection, blood clots, hemorrhage, allergic reaction, and even death. I also realize that the following risks and hazards may occur in connection with hormone treatment:

Possible increased risk for breast cancer, prostate cancer, blood clots, stroke, and heart attacks; cancer screening and yearly physicals should be up to date before initiating treatment. We will evaluate health risks every three to six months.

Evaluation, labs, and other testing or results may be brought in from other providers, and I authorize Lemon-AID Medical Management to obtain, review, and rely on those records in directing my treatment.

I understand that certain complications may result from the use of any prescription medications, which include but are not limited to allergic or adverse drug reactions, paralysis, brain damage, or even death. I accept and assume the risks inherent in hormone treatment and prescription medication use, and I release Lemon-AID Medical Management and its affiliated providers and staff from liability for any harm or adverse reaction arising from those inherent risks, or from any outcome that does not meet my expectations, where care has been provided in accordance with applicable professional standards. Nothing in this form releases any party from liability for professional negligence or willful misconduct or waives any right that cannot be waived by law.

I understand that hormone treatment carries risks that cannot be eliminated even when care is provided properly, and that individual results vary and cannot be predicted. Knowing this, I choose to proceed voluntarily, and I assume responsibility for the risks inherent in the treatment I have requested.

I also accept responsibility for my own role in my care. I agree to give complete and accurate information about my medical history, medications, and supplements; to follow the treatment plan and dosing instructions I am given; to complete required lab work, monitoring, and follow-up visits, including evaluation of health risks every three to six months; to keep cancer screening and annual physical examinations current; and to report new or worsening symptoms promptly. I understand that if I do not do these things, my treatment may be less effective or unsafe, and I accept responsibility for the consequences of not following medical advice or of declining recommended testing or follow-up.

I understand that I may refuse this treatment or discontinue it at any time, and that I may ask questions or request further explanation before or during treatment. I understand the risks of not being treated have been explained to me, and that discontinuing hormone treatment may itself carry risks that I should discuss with my provider first.

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I have been given an opportunity to ask questions about my condition, alternative forms of treatment, risks of non-treatment, the treatment procedures to be used, and the risks and hazards involved. I believe I have sufficient information to give this informed consent. I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in, and that I understand its contents.

_____ I AGREE _____ I DO NOT AGREE to the treatment(s) and procedure(s) listed above.

Patient Signature _____ Date _____

Patient Printed Name _____

Provider or Witness Signature _____ Date _____

Provider Printed Name and Title _____

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