BIO-IDENTICAL SOTTOPELLE INFORMED CONSENT

I have been informed of the following:

- I understand the reason for the procedure is: hormone replacement therapy using Estradiol and/or Testosterone.
- In order for the doctor to accurately assess me, I must fully divulge my medical history and I attest that this information is complete to the best of my knowledge.
- Hair loss is a rare occurrence including the growth of facial hair.
- Some redness and bleeding at the injection site may occur. This will usually dissipate in a minimal amount of time.
- I understand infection might occur as a result of this procedure.
- The dosage may aggravate fibroids or polyps, if they exist.
- In women, transient breast tenderness lasting 7-10 days may occur.
- In men side effects, while rare, may include decreased sperm count, decreased testicular mass and possible prostate enlargement.
- Acne is a rare occurrence from testosterone therapy.
- LOCAL ANESTHESIA: The administration of anesthesia also involves risks; most importantly, a rare risk of reaction to medication causing death. I consent to the use of such anesthetics as may be considered necessary by the medical professional, physician or practitioner responsible for these services. _____X
- I understand that no guarantee or assurance has been made as to the results of the procedure and that it may not cure any condition I may have.

I will inform my practitioner of any changes in my medical history, current medications, and/or any changes relevant to this procedure prior to any future treatments.

I have read the above and I agree to accept the risk of the procedure. All my questions have been answered to my satisfaction. I agree to release the facility and the medical practitioner from any liability arising from the procedures.

Client:_____ Date:_____

Print Name:_____

Practitioner:_____ Date:_____