Alpha Male Health & Testosterone Clinic Policies

PATIENT CONSENT FOR HORMONE RESTORATION AND TREATMENT WITH Alpha Male Health & Testosterone Clinic **If you have any questions, please feel free to ask us. Please initial each point acknowledging you understand that:**

_____ If you are late or miss your appointment, you may be subject to a $50 fee.

_____Services must be paid for at the time of service.

_____Health insurance typically does not cover services provided at **Alpha Male Health & Testosterone Clinic** If you want to seek insurance reimbursement, we would be happy to provide you itemized invoices that you can submit to your insurance company.

_____Testosterone is considered a controlled substance. I agree that I will take my medications as prescribed. I agree to follow my medical providers instructions. I also agree that I will not sell or share my prescriptions to other individuals.

_____I understand that treatments used at **Alpha Male Health & Testosterone Clinic** might not be considered a medical necessity. Treatments rendered are for the purpose of improving your quality of life through hormone restoration, nutritional and supplemental counseling, and possibly weight loss treatment.

_____ I agree that if I am having any side effects or become sick, that I will follow up with my primary care provider or go to an urgent care or emergency department.

_____I acknowledge that Dr. **Sarah Phillips, NP** and **Alpha Male Health & Testosterone Clinic** are not my primary care provider unless I elect them so. I agree that I will continue with routine care through my primary care provider and notify them of treatments prescribed at **Alpha Male Health & Testosterone Clinic**

_____I understand that there are no refunds for services or products rendered. We cannot accept back used medications once they have been dispensed per state regulation.

_____I understand that having an appointment with **Alpha Male Health & Testosterone Clinic** does not necessarily entitle me to being issued a testosterone prescription. Every individual is different and it is at the medical providers discretion to issue a testosterone prescription.

_____I understand that I must maintain my follow up appointments to remain on treatment. It is important that lab work is monitored regularly for safety purposes. It is important that Dr. Sarah Phillips, NP manages my treatment and it is at their discretion to provide

_____I acknowledge that I have been advised of the risks and benefits of treatment. I also acknowledge that I have been advised of possible complications and side effects. I understand the risks, benefits, complications, and side effects of treatment.

_____I am voluntarily requesting treatment with **Alpha Male Health & Testosterone Clinic** and Dr. Sarah Phillips, NP in regards to hormone replacement therapy and additional treatment modalities as determined by a mutual decision between myself and the medical provider even if my hormone levels are considered to be in normal range for my age based off of other medical society recommendations and guidelines.

_____I do not hold any medical practitioner of **Alpha Male Health & Testosterone Clinic** responsible for performing prostate cancer screening, colon cancer screening, digital rectal exams, or other age-related preventive care. I agree that I will follow up with my primary care provider to obtain these screenings and I hold **Alpha Male Health & Testosterone Clinic** and Dr. Sarah Phillips, NP harmless if an adverse event occurs during my treatment. I will ensure that my primary care provider provides the results of such screenings to Alpha Male Health & Testosterone Clinic as this could change the treatment prescribed to me.

I have read, understand and agree to all of the above statements.

Print Name:_____

Signature:_____Date_____