

## DISCLOSURE AND CONSENT for Medical and Surgical Procedures

*TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not 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 make you better informed so you may give or withhold your consent to the procedure.*

I (we) voluntarily request Dr. DeMattia as my physician and such associates, technical assistants and other health care providers as they may deem necessary, to treat my condition which has been explained to me (us) as:

Menopause    Andropause    Thyroid Disease    Other: \_\_\_\_\_

I (we) understand that the following surgical, medical and/or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize these procedures:

Lab work, Medications, Hormone replacement & Education

I (we) understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I (we) authorize my physician, and such associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgment.

I (we) understand that no warranty or guarantee has been made to me as to result or cure.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical and/or diagnostic procedures planned for me. I (we) realize that common to surgical, medical, and/or diagnostic procedures include, but not limited to is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I (we) also realize that the following risks and hazards may occur in connection with this particular procedure:

**Possible increased risk for breast cancer, prostate cancer, blood clots, stroke and heart attack. Cancer screening and yearly physical should be up to date before initiating treatment. Health risk will be evaluated every 6 months. Evaluations, labs, and other testing or results may be brought in from PCP.**

I (we) understand that certain complications may result from the use of any prescription medication which includes but is not limited to drug reaction, paralysis, brain damage or even death.

I (we) have been given an opportunity to ask questions about my condition, alternative forms of treatment, risks of non treatment, the procedures to be used, and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give this informed consent.

I (we) certify this form has been fully explained to me (us), that I (we) have read it or have had it read to me (us), that the blank spaces have been filled in, and that I (we) understand its contents.

X \_\_\_\_\_ DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ AM/PM

Patient signature

\_\_\_\_\_ Witness