CENTER FOR
REGENERATIVE HEALTH

**Consent for Hormone Supplementation Therapy**

I request and consent to the administration of hormones and oral supplements and authorize that these will be prescribed by Tam Tran, APRN-Rx. I acknowledge that there are no guarantees or assurances made with respect to the benefit of hormone supplementation therapy prescribed for me

I understand that I will be in charge of injecting/administering these hormones and supplements prescribed to me. I will conform and comply with the recommended doses and methods of administration.

I understand that initial blood tests will be performed to establish my baseline hormone levels. I agree to comply with requests for ongoing testing to assure proper monitoring of my hormone levels. I agree to report to Tam Tran, APRN-Rx any adverse reaction or problems that might be related to my hormone therapy. I understand that with hormone supplementation there are possible risks and complications if I do not comply with the recommended dosage.

I have not been promised or guaranteed any specific benefit from administration of this therapy. I understand that hormone supplementation for rejuvenation purposes is a new specialty and there are no guarantees with respect to the treatment prescribed.

I understand that the role of Tam Tran, APRN-Rx is for hormone replacement only. I agree that I am and will be under the care of another medical provider for all other medical conditions.

I have been informed that insurance companies and Medicare do not pay for hormone supplementation therapy. I, therefore, agree to pay for all services including laboratory and pharmacy charges myself, with the understanding that I will not be reimbursed by my insurance company.

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 what I am signing and hereby request and consent to treatment using hormone supplementation therapy.

Print Patient Name______________________________________________DOB___________________________________

Patient Signature_______________________________________________Date___________________________________

Medical Provider Signature______________________________________Date___________________________________

1441 Kapiolani Blvd, Suite 1902. Honolulu, HI 96814. Phone: 808-784-0226 Fax 808-585-2958
www.CenterForRegenerativeHealth.com