Her Clinic Policies

PATIENT CONSENT FOR HORMONE RESTORATION AND TREATMENT AND/OR WEIGHT LOSS WITH HER CLINIC LLC

If you have any questions, please feel free to ask us. Please initial each point acknowledging you understand that:

_____ If you are late for your appointment, you may be asked to reschedule at the discretion of the provider. If you miss your appointment without notice, particularly if you do if more than once, 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 Her 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 and Phentermine are 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 Her 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/or weight loss treatment.

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

_____I acknowledge that Her Clinic and Its medical providers are not my primary care provider or gynecologist. I agree that I will continue with routine care through my primary care provider and OB/GYN and notify them of treatments prescribed at Her 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 Her Clinic does not necessarily entitle me to being issued a prescription for hormone replacement, weight loss medications or additional medications. Every individual is different and it is at the medical providers discretion to issue a 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 Her Clinic 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 Her Clinic and Its medical providers in regards to hormone replacement therapy, weight loss and/or 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 Her Clinic responsible for performing breast/ovarian/cervical/uterine cancer screening, colon cancer screening, PAP smears, pelvic exams, mammograms, or other age-related preventive care. I agree that I will follow up with my primary care provider and/or OB/GYN to obtain these screenings and I hold Her Clinic and Its medical providers harmless if an adverse event occurs during my treatment. I will ensure that my primary care provider and/or OB/GYN provides the results of such screenings to Her 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_____