

Georgia Wellness Solutions

HORMONE REPLACEMENT THERAPY (HRT) / BIOIDENTICAL HORMONE REPLACEMENT THERAPY (BHRT) PATIENT AGREEMENT AND INFORMED CONSENT

Purpose of Therapy

I understand that Hormone Replacement Therapy (HRT), including Bioidentical Hormone Replacement Therapy (BHRT), is intended to help address symptoms related to hormone imbalance. These symptoms may include, but are not limited to, fatigue, sleep disturbances, mood changes, decreased libido, weight changes, cognitive changes, and overall decline in quality of life. Treatment is individualized based on clinical evaluation, symptoms, and laboratory testing.

Description of Treatment

Hormone therapy may include the use of bioidentical or other hormones such as estrogen, progesterone, testosterone, DHEA, or related compounds. These may be administered in oral, topical, injectable, or other medically appropriate forms. Treatment plans are customized and may change over time based on response, lab values, and clinical judgment.

Georgia Wellness Solutions utilizes saliva hormone testing as the primary laboratory method for evaluating hormone levels and guiding treatment recommendations. We do not utilize blood hormone testing as a basis for hormone therapy management. Laboratory results obtained from other practitioners, clinics, or testing methods, including bloodwork, are not accepted as the basis for treatment recommendations at Georgia Wellness Solutions.

Expected Benefits

Potential benefits of hormone therapy may include improved energy, mood, sleep quality, mental clarity, libido, metabolic function, and overall well-being. I understand that individual results vary and that no specific outcomes are guaranteed.

Risks and Side Effects

I understand that hormone therapy carries potential risks and side effects, which may include but are not limited to acne, fluid retention, mood changes, weight changes, breast tenderness, headaches, changes in cholesterol levels, elevated red blood cell counts, and changes in liver function tests. Hormone therapy may increase the risk of blood clots, cardiovascular events, and hormone-sensitive cancers in certain individuals. Not all risks are known, and individual responses to therapy vary.

Monitoring and Follow-Up

I understand that ongoing monitoring is required for safe hormone therapy. This includes initial and follow-up laboratory testing, routine office visits, and age-appropriate health screenings such

as mammograms, pelvic exams, prostate screening, or other tests as recommended. Failure to comply with recommended monitoring may result in discontinuation of therapy.

Alternatives to Therapy

I understand that alternatives to hormone therapy include lifestyle modifications, nutritional changes, non-hormonal medications, or choosing no treatment. These options have been discussed with me.

Fertility and Pregnancy

I understand that hormone therapy may affect fertility and is not a form of birth control. I agree to notify my provider immediately if I become pregnant, am planning pregnancy, or am breastfeeding.

Financial Responsibility

I understand that I am financially responsible for all costs associated with hormone therapy, including consultations, laboratory testing, medications, and follow-up visits, unless otherwise stated in writing.

Georgia Wellness Solutions does not bill or submit claims to insurance companies for hormone therapy services. I understand that services are provided on a self-pay basis and that I am solely responsible for payment, regardless of insurance coverage or reimbursement eligibility.

Voluntary Participation

I understand that participation in hormone therapy is voluntary. I may discontinue treatment at any time. No guarantees have been made regarding results or symptom improvement.

Patient Acknowledgment and Consent

I acknowledge that I have read and understand this agreement. I have had the opportunity to ask questions and have received satisfactory answers. I understand the potential benefits, risks, and alternatives to hormone therapy. I voluntarily consent to hormone replacement therapy as prescribed by Georgia Wellness Solutions.

Patient Name: _____

Patient Signature: _____

Date: _____

Witness Name : _____

Witness Signature : _____

Date : _____