HORMONE REPLACEMENT CONSENT

Please read this form entirely. It contains information to assist you in making a decision to have a specific therapy. Initial each paragraph if you understand it. If you do not understand it, do not initial it and each paragraph will be discussed with you separately. There are risks and complications that may result from this therapy, they are rare, but do exist and you must be aware of them.

Testosterone has many beneficial effects, including increasing bone strength and density, increasing red blood cell production, driving sexual function and libido, providing a cardioprotective effect and increasing muscle strength. The expectation of treatment is improvement in symptoms of hormone deficiency and possibly decreased health risks.

_____ Possible side effects include breast swelling or tenderness, acne, increased body hair, excess red blood cell production, sleep apnea, aggressive or hostile mood, excess libido.

_____ Rare but may include blood clots, stroke, tendon rupture.

_____ I understand that TRT does not increase the risk for prostate cancer, however TRT will stimulate complications of existing prostate cancer.

_____ I understand that the bulk of studies show TRT will reduce the risk of heart disease but there are conflicting studies which show an increased risk of heart disease with TRT.

_____ The above listed risks may occur, but there may be unforeseen risks and risks that are not included on this list. Some of these risks, if they occur, may necessitate hospitalization and/or extended outpatient therapy to permit adequate treatment.

_____ I will conform and comply with the recommended dosing of TRT. If recommended, I will obtain baseline and periodic lab tests to assure proper monitoring of my TRT.

_____ I understand that medicine is not an exact science and that no guarantees are offered regarding my expected results. I am aware that it is possible that this treatment will not work for me.

I have read the foregoing information, it has been explained, and I understand it. All of my questions have been answered. By executing this form, I am indicating that I have no questions whatsoever and I give my full informed consent to have TRT prescribed.

I _____, confirm that I have had consultation with the providers at Active Wellness regarding the risks and benefits of testosterone supplementation. Although testosterone replacement therapy (TRT) has been utilized safely and effectively, it is necessary to understand the potential risks. You should be aware of the alternatives to testosterone replacement therapy, including not receiving this treatment. I understand that this prescription for testosterone is indicated for treatment of hypogonadism (testosterone deficiency) based upon my medical history, physical exam findings and laboratory tests. This may include patients with a low testosterone level, as well as patients with a level reported in the normal range but felt to be suboptimal based on medical history and physical findings. I

understand that the purpose of TRT is to improve symptoms of low or suboptimal testosterone levels including decreased energy, exercise endurance, libido, mental focus and sense of overall wellbeing. I understand that there are occasionally complications of TRT including acne, irritability, increased estrogen levels, fluid retention, testicular atrophy, decreased sperm count, increased blood pressure, exacerbation of sleep apnea, male pattern baldness and breast enlargement. There are conflicting studies regarding the cardiac risks of TRT and the definitive risk is not known at this time. I understand that TRT may affect fertility and should not be used if attempting to father a child now or in the future. I understand that questions have been raised about testosterone as a cause of prostate cancer, but studies have been inconclusive. Patients with a history of prostate cancer are not a candidate for TRT. If a patient develops prostate cancer while on TRT, the testosterone will be discontinued immediately. I understand that TRT can occasionally change cholesterol levels, red blood cell levels, PSA levels, liver function enzymes and various hormone levels. These labs will be monitored through periodic blood tests, usually performed every 3-6 months. I understand that there is no guarantee as to the result of TRT and that if I stop treatment, my condition may return or get worse. I understand that TRT will not be given to enhance athletic performance. I certify that I have read the above consent and fully understand it. I believe I have adequate knowledge upon which to base informed consent. I fully understand what I am signing and hereby request and consent to treatment with supplemental testosterone. Patient Signature_____ Date_____ Physician Signature_____ Date_____

_____1. This is my consent for Active Wellness, with any physician or nurse who is working with the company, to begin treatment for testosterone deficiency, weight management, IV Fluid, vitamin therapy (e.g. B12), or other treatment provided.

_____2. It has been explained to me and I fully understand that occasionally there are complications of this treatment.

_____3. Acne.

_____4. Breast Enlargement.

_____5. Mood Swings

_____6. Extra fluid in the body. This can cause problems for patients who have heart, kidney or liver disease.

_____7. Sleep disturbance. This is called sleep apnea and is more likely in patients who have lung disease or are overweight.

_____8. Prostate Enlargement which may cause problems with urinating.

_____9. Changes in cholesterol levels, red blood cell levels, PSA levels, and liver function enzymes, and other hormone levels which will be monitored with periodic blood tests.

_____10. I understand that testosterone replacement therapy may increase complications and adverse outcomes, including death, for those with known heart disease. If I am under 65 with known heart

disease I must be cleared by a Cardiologist or my primary care provider. If I am 65 years or older, with or without known heart disease, I must be cleared by a Cardiologist or my primary care provider.

_____11. I understand that I will have periodic blood tests to monitor my blood levels and that this can be painful and leave bruises on the skin.

_____12. The use of testosterone products may lead to blood clots in the veins, Venous Thromboembolism (VTE) and Deep Vein Thrombosis (DVT).

_____13. I understand there is no warranty or guarantee as to the result and that my condition may return or become worse.

_____14. I have had an opportunity to discuss with Active Wellness and its medical practitioners my complete past medical and health history including any serious problems and/or injuries. All of my questions concerning the risks, benefits, and alternatives have been answered. I am satisfied with their answers.

_____15. I understand that the physical exam by Active Wellness does NOT replace a full physical exam by a personal physician.

_____16. I agree to have my personal physician to perform a yearly full physical exam including a digital rectal exam, lipid profile, cholesterol levels, and a comprehensive metabolic panel. If I do not have a personal physician Active Wellness will assist in locating one for me.

_____17. FERTILITY - I understand that the use of exogenous testosterone may result in testicular atrophy as well as lowering of my sperm count that can diminish

my fertility/ability to father a child while on therapy and for an indeterminate time into the future.
_____18. Certain medical authorities recommend HCG to be given twice weekly to minimize testicular atrophy and to increase fertility/ability to father a child.

_____19. I understand that normal ranges for testosterone are generally established by reference to morning levels and that men's testosterone levels generally decline in the afternoon.

_____20. I understand that men's testosterone levels can vary significantly between tests, even when the tests are conducted at the same time of day.

_____21. I understand that the Active Wellness treatment protocol recommends testosterone replacement therapy if I have a total testosterone level of less than 400 nanograms per deciliter, 430 nanograms per deciliter and certain symptoms, or 600 nanograms per deciliter if my free testosterone is below 11 nanograms per deciliter. I also understand that according to the Endocrine Society Guidelines, the threshold for testosterone replacement therapy should be in the range of 200 to 300 nanograms per deciliter.

_____22. I understand that certain medical guidelines, including the Endocrine Society Guidelines and the guidelines of the American Urological Association, state that blood tests for the purposes of diagnosing hypogonadism should be performed in the morning and that two morning tests should be performed before starting patients on TRT.