CONSENT FOR CARE & TREATMENT

Please read this form in its entirety and initial each paragraph below to signify understanding and acceptance

_____ **I have read and understand that there may be complications arising from or related to treatment as described in my Treatment Plan and explained by my Provider. I have had an opportunity to discuss with my Provider my complete past medical and health history including any serious problems and/or injuries, as well as my family history of diseases and conditions. All of my questions concerning the risks and benefits of treatment have been answered. I am satisfied with the answers and desire to commence with my Treatment Plan, knowing the risks and potential side effects involved.**

_____ **I understand that I will have periodic blood tests to monitor my blood levels of testosterone and I consent to such testing. I agree to follow my Treatment Plan dosing protocol and will contact my Provider if I experience sides effects, such as but not limited to, breast swelling or tenderness, acne, increased body hair, sleep apnea, aggressive or hostile mood and/or excess libido.**

_____ **I understand that the physical exam by my Viking Men's Health Clinic provider does *NOT* replace a full physical exam by my personal physician and I agree to have my personal physician (not Viking Men's Health Clinic) perform a full physical exam including a digital rectal exam and testicular exam on an annual basis.**

_____ **I understand that the use of Testosterone will result in a lowered sperm count, which could impact my fertility/ability to have children.**

_____ **I agree to be contacted via text and email for the purpose of appointment confirmation and reminders. I can opt in/out at any time with written notice.**

Patient Name: _____

Patient Signature:_____

Date Signed:_____