VIKING
MEDICAL GROUP

Specialized Care for Men & Women

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 Medical Group Provider does *NOT* replace a full physical exam by my personal physician and I agree to have my personal physician (not Viking Medical Group) 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:_____