Kick Some Mass Clinical Procedures

PATIENT CONSENT TO HORMONE RESTORATION, WEIGHT LOSS AND NUTRITIONAL THERAPY

Please initial, indicating you understand and agree with the following statements. Then sign below. If you have any questions, please discuss the same with Dr. Jeffrey Ruterbusch before signing below. If under the age of 21 a parent or guardian must also sign.

_____ The number of patients we see is limited by appointment only. Missed appointments cause additional expense and inconvenience to other patients. Please notify us twenty-four (24) hours in advance if you are unable to keep your appointment. **BHRT patients may be subject to $75 administrative fee for missed appointments in which Kick Some Mass is not notified in advance.**

_____ Most health insurance companies (Campus, Blue Cross, Medicare, and Medicaid) typically **do not** provide coverage for medically monitored weight-loss and Bio-Identical Hormone Restoration Therapy (BHRT). **Therefore, we do not take any form of payment from third party companies and all services must be paid for at the time services are rendered by cash, check, or credit card.**

_____ **I understand that if I choose to file a claim with a third-party insurance, Kick Some Mass will provide receipts of transaction, but should not be expected to take further action.**

_____ If my treatment includes prescription medications (Hormones, Appetite Suppressants) I will carefully follow the instructions given, notify the doctor of any change in my medical history (especially heart or blood pressure problems) and not resell the medication nor will I share it with any friend or family member, EVER. I will not visit other doctors for the purpose of obtaining additional or duplicate medication of the same type.

_____ I understand any treatments rendered through Kick Some Mass s are solely for the purpose of hormone balancing/restoration, body-fat reduction, and preventative medicine. We are not capable of serving as your primary care facility. If I become ill, I should contact my personal physician or visit an urgent care facility. If I become ill, I will discontinue any diet or weight-loss medication from this clinic until it is determined safe to resume the weight control program (Please call if uncertain).

_____ I will consult my primary care physician and/or endocrinologist (medical physician) to encourage and facilitate physician communication with Dr. Ruterbusch regarding my treatments.

_____ I understand that I will not be refunded for any lab orders or appointments once the service is provided, even if I do not qualify for any treatment.

_____ I understand that I will only receive a prescription when medically necessary and that I do not automatically qualify for Testosterone Therapy upon my initial assessment. Obtaining a prescription is always at the physician's discretion and is determined based on medical assessment and a diagnosis.

_____ I understand that I will not receive a refund for any medications once they are dispensed from the pharmacy. Once medications leave the pharmacy, they cannot be returned.

_____ I have been advised and do understand all the risks and possible complications of BHRT, as well as noncompliance with Dr. Saya's recommended dosage. Further agree to administer all medications as directed by Dr. Ruterbusch.

_____ I agree to immediately report to Dr. Ruterbusch any adverse reactions or problems, of whatever nature, whether said matters relate to BHRT treatment.

_____ I understand that restoring and balancing hormones accurately requires follow up blood work and monitoring. **These follow- ups may require additional costs for the patient. If I fail to submit to requested follow- ups I understand that my physician, at his/her discretion, will discontinue my therapy until requested information is received.**

_____ I understand that if I am an out of state patient, I will provide current and updated Physical Exams every 6 months or as otherwise requested, to continue treatment.

_____ I understand that **NO PRESCRIPTION WILL BE PROVIDED UNLESS A CLINICAL NEED EXIST BASED ON REQUIRED LAB WORK, PHYSICIAN CONSULTATION, PHYSICAL EXAMINATION AND/OR CURRENT MEDICAL HISTORY. PLEASE NOTE, AGREEING TO LAB WORK AND PHYSICAL EXAM DOES NOT AUTOMATICALLY EQUATE TO CLINICAL NECESSITY AND A PRESCRIPTION**.

_____ I hereby request and consent to the administration of BHRT and/or nutritional supplements by Dr. Ruterbusch for the purpose of restoring optimal levels, even where lab test results are within reference ranges for age and/or in circumstances where other medical organizations do not recommend the same.

MEN ONLY:

_____ I do not hold Dr. Ruterbusch responsible for performing prostate cancer screening, PSA tests and/or rectal exams. I will consult with my primary care physician or urologist (medical physician) about them and provide all appropriate medical records and/or facilitate inter-physician communication regarding such evaluations. I understand a decision about treatment may depend on this information.

I have read, understand and agree to all the above statements.

Patient signature: _____

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