Heights Holistic Wellness Informed Consent to Treat

926 Main St. #6 Billings MT, 59105

The Nature of the Treatment

I hereby give my consent to evaluation and treatment by Heights Holistic Wellness, Theresa Kinney NP-C and other healthcare practitioners of the following specified condition(s):

☐ Women: menopause or menopausal symptoms (including potential repletion of estrogen/estradiol, progesterone, DHEA, testosterone)

☐ Women: other hormone imbalances - Thyroid abnormalities, Adrenal abnormalities

☐ Women: other – Nutritional deficiencies, IV infusion services, weight loss, etc. and (any other type of treatment services you might want to have).

In addition:

☐ I acknowledge that treatment with testosterone, bioidentical hormone replacement therapy, B12, and thyroid optimization are considered off label use of the associated medications and have not been FDA approved for the use of health optimization, wellness, weight loss and/or for anti-aging purposes unless there is true medical necessity.

I agree to the administration of hormone replacement therapy and drugs designed to alter hormone levels, all as appropriate to my specific diagnosis, particular condition and treatment objectives.

Name_____Date_____

Alternative Treatments

I have been informed about alternative treatments and understand:

1. That we can leave the hormone levels alone.
2. Treating age related diseases as they appear.
3. Using pharmaceutical agents that are not bioidentical in nature (synthetics)

☐ I understand the alternative treatments and am choosing to consent to the treatment plan prepared for me by Heights Holistic Wellness to address the condition/conditions listed above.

Name_____Date_____

Side Effects and Potential Risks

☐ Women: I understand that the possible side effects for women on estrogen, progesterone and/or testosterone may include breast swelling and/or discomfort, fluid retention, dizziness, thickening of the lining of the uterus (break-through bleeding), acne, unwanted hair growth, headaches, slight deepening of the voice, slight enlargement of the clitoris, potential increased risk of blood clots, and worsening of (1) ovarian cysts, (2) uterine fibroids, (3) endometriosis, and (4) fibrocystic disease.

☐ Women: I understand that the possible serious side effects for women on hormone replacement therapy including estrogen, progesterone and/or testosterone can be an acceleration in the growth of gynecological cancers, elevations in hematocrit which could potentially predispose one to a blood clot, and cardiovascular disease including heart attacks, strokes, and blood clots.

Most of the common side effects resolve with time. Many of these can be treated by changing your testosterone dose and adding other medications.

I acknowledge that I should take extreme precaution if I am to use topical testosterone products. If a child or women accidently is exposed to the testosterone cream/lotion on my body, it could cause a significant increase in their hormone levels which could result in possible side effects.

Signature:_____Date_____

Safety of Hormone Replacement

Although, in my medical providers opinion, the majority of data points toward safety, there remains controversy regarding the correlation between the use of bioidentical hormone therapy and cancer. Recent data demonstrates that natural progesterone and estriol/estradiol may be protective against breast cancer.

Available data supports the safety of hormone replacement therapy in women, and it is of the opinion of and/or Theresa Kinney NP-C that treatment is safe, but there still remains controversy regarding the correlation between the use of bioidentical hormone replacement and cardiovascular events such as but not limited to: strokes, heart attacks, and blood clots. Some studies have shown correlations between hormone replacement therapy and cardiovascular disease while others show no correlation or even a benefit in preventing cardiovascular disease.

I understand that careful surveillance and close monitoring are requirements of all patients to minimize any possible risk. I understand that Heights Holistic Wellness AND Theresa Kinney NP-C will monitor my hormone levels and various other laboratory values as they pertain to my treatment goals. However, I also understand that an integral part of health maintenance is obtaining and remaining up to date with age appropriate screening tests aimed at early detection of life-threatening diseases.

☐ I understand that close monitoring is required by all patients to minimize and prevent any possible risks. I understand that Heights Holistic Wellness will monitor my blood work including hormone levels. I also understand that it is important to stay up to date with routine screening and health maintenance by my primary care provider to prevent and detect any possible life-threatening diseases or conditions.

☐ I agree to obtain and remain up to date on all age-appropriate screenings including, but not limited to, DEXA scans, mammograms (you should have these), PAP smears, pelvic exams, colonoscopies, cardiac screenings, and any other type of recommended health screenings. I agree to obtain these screenings through the direction of my primary care provider and/or OB/GYN and/or cardiologist and will not hold Heights Holistic Wellness &/or Theresa Kinney NP, or any additional Heights Holistic Wellness staff responsible or liable for performing these health maintenance screenings or the treatment of any other conditions not relevant to my treatment goals with Heights Holistic Wellness.

☐ Heights Holistic Wellness Theresa Kinney NP-C strongly recommend obtaining yearly mammograms. I understand that certain types of breast cancer, once present, can be stimulated to grow faster by estrogen that is prescribed or even the estrogen within your body. Taking estrogen

therapy with an active breast cancer could potentially decrease your chances of survival. Therefore, it is imperative to obtain appropriate yearly screenings.

☐ I agree to notify Heights Holistic Wellness Theresa Kinney NP-C immediately if I am to become pregnant while on hormone replacement therapy and to stop it immediately. I understand that being on hormone therapy and becoming pregnant could present a risk to an unborn child.

☐ I want to initiate treatment at Heights Holistic Wellness and I give permission to Heights Holistic Wellness and Theresa Kinney NP-C and additional staff of Heights Holistic Wellness to begin treatment without knowing results of age-appropriate and health maintenance screenings. In doing so, I release Heights Holistic Wellness Theresa Kinney NP-C and other healthcare practitioners of any claims of liability for cardiovascular events, ovarian cancer, breast cancer, uterine cancer, cervical cancer and/or colon cancer. Further, I agree to immediately notify Heights Holistic Wellness, Theresa Kinney NP-C and additional staff of Heights Holistic Wellness of any abnormal findings on any health screenings done by my primary care provider.

Signature:_____Date_____

My Obligations and Representations

Any questions I have regarding this treatment have been answered to my satisfaction. I understand that I will be responsible for administering the hormones and/or medications prescribed to me if I do not have them administered to me in clinic. I also promise to comply with the dosages and frequency of medications prescribed to me.

I certify that I am under the regular care of a primary care provider or an OB/GYN or a Women's Health Specialist for any other conditions I might have or am found to have. I will consult with my primary care provider or specialist regarding any other condition I might have. I understand that if I do not have a primary care provider, that I will be encouraged to seek one out. I acknowledge that I am seeking care at Heights Holistic Wellness for the specific services Heights Holistic Wellness offers. I acknowledge I am not wanting to establish primary care with Heights Holistic Wellness and I am here for specialized care including hormone restoration, and any additional etc.

I have reviewed the mentioned risks and have determined the benefits outweigh the possible risks associated with hormone restoration and treatment with Heights Holistic Wellness. I release any claim in court or any type of complaint that could result from treatment with Heights Holistic Wellness and Theresa Kinney NP-Cand any other staff associated with Heights Holistic Wellness and will not hold liable any provider or staff of Heights Holistic Wellness

I understand that treatment modalities utilized by Heights Holistic Wellness might not be supported by scientific/medical literature and could be seen as experimental or based off

anecdotal claims. Many medical providers, including endocrinologists and OB/GYNs, might see these types of treatments as not medically necessary.

Signature:_____Date_____

Consent

I hereby authorize Heights Holistic Wellness, Theresa Kinney NP-C and additional staff of Heights Holistic Wellness to evaluate and treat conditions that I have consented for. I consent to obtaining blood work before treatment so hormone levels can be monitored, and appropriate treatment can be prescribed. I certify that I am signing this under my free will and am competent to make my own medical decisions.

Print Name:_____

Signature:_____Date_____

Indemnification Clause

I, _____, agree to indemnify, defend, protect, and hold harmless Theresa Kinney NP-C, medical providers employed by Heights Holistic Wellness and Heights Holistic Wellness LLC; and their respective officers, directors, employees, stockholders, assigns, successors and affiliates from, against and in respect of all liabilities, losses, claims, damages, judgements, settlement payments, deficiencies, penalties, fines, interest and costs, expenses suffered, sustained, incurred or paid by the indemnified parties, in connection with, results from or arising out of, directly or indirectly, Theresa Kinney NP-C, medical providers employed by Heights Holistic Wellness LLC rendering medical care, services, advice, and/or treatment, my failure to disclose all relevant information regarding my medical and physical condition, acts or omissions, of (Theresa Kinney NP-C, Heights Holistic Wellness harm or injury resulting from medical care or pharmaceuticals provided directly or indirectly by Theresa Kinney NP-C or Heights Holistic Wellness LLC. I am aware of the potential side effects associated with the above treatments, accept all the risks involved in taking the medication and will not seek indemnification or damages from the indemnified parties.

Printed Name:_____

Signature:_____Date:_____

Witness:_____Date:_____