# ConnectCare& Wellness LLC (CCW) Clinical Policies

*PATIENT CONSENT FOR HORMONE RESTORATION AND TREATMENT WITH (CCW).*

**If you have any questions, please feel free to ask us. Please initial each point acknowledging you understand that:**

If you are late or miss your appointment, you may be subject to a $50 fee.

Services must be paid for at the time of service.

Health insurance typically does not cover services provided at (ConnectCare& Wellness). If you want to seek insurance reimbursement, we would be happy to provide you itemized invoices that you can submit to your insurance company.

Testosterone is considered a controlled substance. I agree that I will take my medications as prescribed. I agree to follow my medical providers instructions. I also agree that I will not sell or share my prescriptions to other individuals.

I understand that treatments used at (ConnectCare& Wellness) might not be considered a medical necessity. Treatments rendered are for the purpose of improving your quality of life through hormone restoration, nutritional and supplemental counseling, and possibly weight loss treatment.

I agree that if I am having any side effects or become sick, that I will follow up with my primary care provider or go to an urgent care or emergency department.

I understand that there are no refunds for services or products rendered. We cannot accept back used medications once they have been dispensed per state regulation.

I understand that having an appointment with (CCW) does not necessarily entitle me to being issued a testosterone prescription. Every individual is different and it is at the medical providers discretion to issue a testosterone prescription.

I understand that I must maintain my follow up appointments to remain on treatment. It is important that lab work is monitored regularly for safety purposes. It is important that (MEDICAL PROVIDER) manages my treatment and it is at their discretion to provide

I acknowledge that I have been advised of the risks and benefits of treatment. I also acknowledge that I have been advised of possible complications and side effects. I understand the risks, benefits, complications, and side effects of treatment.

I am voluntarily requesting treatment with (CCW)  in regards to hormone replacement therapy and additional treatment modalities as determined by a mutual decision between myself and the medical provider even if my hormone levels are considered to be in normal range for my age based off of other medical society recommendations and guidelines.

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

Print Name:_____

Signature:_____Date_____