**Informed Consent ED**

Consent:

You are being seen in a private examination room where you will be attended to by a State Licensed Physician who will examine you, check your general medical condition, ask about any medications you are presently taking, and discuss with you the specific problem for which you have come to the medical clinic:

Erectile Dysfunction (ED)/Premature Ejaculation (PE). The physician may then perform some diagnostic tests, including locating the paired deep arteries (cavernosal arteries) in the penis and measuring “passive” blood flow (when you are not sexually excited). The physician will then administer a test dose of medication designed for your specific problem to the spongy tissue of the penis using an applicator. The test dose of medication contains a combination of commonly used vasodilators including Papaverine, Phentolamine and Prostaglandin E1. This medication will dilate the arteries so that the “active” blood flow (as when you are sexually excited) through the penis can be measured. A partial or full erection lasting 40-60 minutes usually results from this administration. Other effects of this procedure include some mild discomfort or light-headedness mostly due to nervousness. This reaction, while rare, is generally normal. Rarely, the application may produce a full or partial erection lasting longer than two hours. Such prolonged ejection is unusual and only occurs in those who are overly sensitive to the combination used. Should a prolonged erection occur, the physician will advise you on what procedures to follow. These recommended procedures are safe and there is no additional cost to you if they are needed. Infrequently, long term and/or frequent use of the medication can cause scarring. The diagnostic tests and application are necessary for Dr. Jeffrey Ruterbusch to properly and effectively diagnose and treat your complaint. Both the diagnostic tests and the applications are painless and safe. Following the diagnostic tests and the initial test dose, on the very first visit, the physician will prescribe a unique treatment designed to treat the cause of your ED or PE.

I understand and have been advised that I should not receive a test application if I have the following conditions; sickle cell anemia trait, tumor of the bone marrow (multiple myeloma), penile implant, Fabry disease, or malaria By signing below, I acknowledge that I am not presently suffering from any of the above conditions. I further acknowledge that I have not used marijuana, or recreational drugs such as cocaine, heroin, or ecstasy within the last 24 hours. I further acknowledge that I have not used Viagra, Levitra, Cialis or any similar oral erectile medications within the last 24 hours.

Testosterone – I understand that initial blood tests will be performed to establish my baseline hormone levels. I agree to comply with reasonable requests for follow-up testing to assure proper monitoring of my hormone levels. I agree to report to Dr. Ruterbusch any adverse reactions, side effects, or problems that might be related to my hormone therapy, such as mood changes, acne, hair loss, prostate enlargement, breast enlargement, or testicular shrinkage. I understand that with hormone supplementation there are possible risks and complications if I do not comply with the recommended dosages. I understand I will be in charge of administering the hormones and supplements prescribed to me. I will conform and comply with the recommended dosages and methods of administration, which may include injections. I understand that the role of Dr. Ruterbusch is for management of my hormone replacement (ED/PE issues, if applicable) only and that I must seek care from other medical providers for any other medical condition(s).

I understand and agree that Dr. Ruterbusch guarantees that in the event I fail to achieve an erection during the initial visit following the test application, there will be no charge for the office visit. However, I acknowledge that Dr. Ruterbusch cannot guarantee the success of any specific treatment plan, and, in the event that I complete the office visit having achieved an erection, the cost of the office visit, as well as any treatment plan I agree to, including products, tests, medications and services, will not be refundable. I agree that should I elect to purchase a treatment plan from Dr. Ruterbusch, the treatment plan may include a maximum number of doses, the treatment plan, will be sent directly to my address on record and self-administered. Once received, my medications cannot be returned or refunded. I will receive 2-4 months of medication at a time. These medications will be purchased on a monthly fee basis or may be charged up front. Medications will refill as needed and monthly fees will continue until notified in writing to discontinue. I have been informed that I have the right to choose the pharmacy for filling any prescription written.

I fully understand the nature of the above tests, therapy and the possible adverse reactions and side effects. I consent to a medical consultation fee of $199.00 upon completion of the visit and understand that the charges paid for any other treatment plans, including medication(s) used or unused, which I may elect to purchase are final. I consent to the treatment described herein by Dr .Ruterbusch and any further treatment that is necessary if I experience any adverse symptoms or side effects. I also understand that all services provided by Dr. Ruterbusch are considered elective treatment and are not covered by Medicare and many private commercial health insurers. If I have private commercial health insurance, I may request an invoice from Dr. Ruterbusch and seek reimbursement from my health insurer; however, I understand that I am solely responsible for paying Dr. Ruterbusch and I understand that Dr. Ruterbusch makes no guarantees that my health insurer will reimburse me. I understand that any medications ordered for me as part of my treatment plan are unique to my needs and are by law non-refundable.

I understand that Dr. Ruterbusch will maintain medical records and medical charts documenting the services provided to me, as well as my medical history. Dr. Ruterbusch may use and disclose these medical records as described in Kick Some Mass/Dr. Ruterbusch’s Privacy Policy Notice. I authorize Dr. Ruterbusch to analyze my medical information for purposes of improving the care and services provided by Dr. Ruterbusch, including establishing more effective treatment protocols and identifying certain risk factors of his patients. I understand that such analysis may lead to general findings related to ED, PE, and hormone therapy, which Dr. Ruterbusch may seek to publish, but that any general findings or information published or disclosed by Dr. Ruterbusch related to me or my information will not identify me, unless I otherwise expressly consent in writing.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_