**KICK SOME MASS** Dr. Jeffrey Ruterbusch, D.O. NMD
316 Parkridge Avenue
Orange Park, Fl 32065

Phone: (904) 590-0750
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# 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 them with Dr. 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 expenses 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 a $50 administrative fee for missed appointment 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 no take 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, but should not be expected to take further action.**

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

_____ I understand treatment rendered through Kick Some Mass are solely for he 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 care physician or visit an urgent care facility. If I become ill, I will discontinue any diet or weight loss medication(s) 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 endocrinologists (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

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well as noncompliance with Dr. Ruterbusch's recommended dosage. I further agree to administer all medications as directed by Dr. Ruterbusch.

_____ I agree to immediately report to Dr. Ruterbusch any adverse reactions or problems, or whatever nature, whether or not said matters related 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 os state patient, I will provide current and updated physical exam 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 supplement 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 organization do not recommend the same.

MEN ONLY:

_____ I do not hold Dr. Ruterbusch responsible for performing prostate cancer screening, PSA test 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 of the above statements.**

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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## The Nature of the Treatment

I hereby give my consent to evaluation and treatment by Kick Some Mass's staff, physician, Dr. Jeffrey Ruterbusch D.O., and healthcare practitioners of the following specified conditions (s):

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

_____ Men: andropause or associated symptoms (including potential repletion of testosterone and DHEA, potential lowering estrogen/estradiol levels)

_____ Men/Women: other hormone imbalances (please specify)- Thyroid abnormalities, Growth hormone abnormalities (including decreased or suboptimal IGF-1, decreased or suboptimal Vitamin D-3 levels).

_____ Men/Women: other (please specify) – Nutritional deficiencies (vitamin, minerals, amino acids, etc.) Overweight/Obesity (may include medically supervised weight loss with appetite suppressants- phentermine-, injectable (Lipo-B), etc.

_____ Men/Women: other (please specify) _____
_____

I agree to the administration of hormone replacement therapy and/or nutritional supplements, including vitamins, minerals and anti-oxidants and/or drugs designed to alter hormone levels, all as appropriate to my specific diagnosis, particular condition and treatment objectives.

## Alternative Treatment Methods and Their General Nature

The reasonable alternatives to this treatment have been explained to me and they include:

1. Leaving the hormone level as they are.
2. Treating age related diseases as they appear.
3. Using pharmaceutical agents that are not bio identical in nature (synthetics).

_____ I understand the foregoing alternatives and am choosing to consent to the treatment plan prepared for me by Kick Some Mass to address the condition(s) indicated above.

## The General Nature and Extent of Treatment- Related 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. Many of these side effects can be temporary as your body adjust to restoration. Some of these potential side effects can often be addressed by adjusting hormone levels or

prescribing simple remedies. I also understand that if topical hormone replacement treatment (cream, gel, etc.) is prescribed for me that I should take extreme care to avoid any collateral exposure via direct skin-to-skin contact with the application site or exposure to contaminated bed linens, clothes, etc. for any children, pets, co-habitants of the home, or anyone else whom may come into contact with the hormonal treatment/gel. I have been informed that accidental collateral exposure may significantly impact the hormone levels of those affected.

Men: _____ I understand that the possible side effects for men on testosterone replacement are acne, persistent erections, unwanted hair growth/loss, enlargement of the prostate, enlargement of breast tissue (we will monitor and treat estrogen levels), minor testicular atrophy, salt retention, increase in blood pressure, decreased sperm count, an increase in the number of red blood cells (erthrocytosis) with corresponding increase in hematocrit and/or hemoglobin (your blood will be monitored for this). Many of these effects can be temporary as your body adjust to restoration. Some of these potential side effects can often be addressed by adjusting hormone levels or prescribing simple remedies. I also understand that if topical hormone replacement treatment (cream, gel, etc.) is prescribed for me that I should take extreme care to avoid any direct exposure via direct skin-to-skin contact with the application site or exposure to contaminated bed linens, clothes, etc. for any children, pets, co-habitants of the home, or anyone else whom may come into contact with the hormonal treatment/gel. I have been informed that accidental collateral exposure may significantly impact the hormone levels of those affected.

## Safety of Hormone Replacement

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

I understand that careful surveillance and close monitoring are requirements of all patients to minimize any possible risk. I understand that Kick Some Mass 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.

_____ Male Patients: I, _____, agree to obtain and remain up to date on all age appropriate screenings including, but not limited to, colonoscopy, PSA, and DRE (digital rectal exam), cardiac screenings as necessary (stress test, etc.). I agree to obtain these screenings through the appropriate physician(s) (PCP, cardiologist, urologist, etc.) and will not hold Kick Some Mass staff, physician Jeffrey Ruterbusch D.O., or health care practitioners responsible or liable for performing these screenings or treatment/managing any abnormal findings relating to these screenings. I acknowledge that Kick Some Mass would like to be supplied with copies of my current and future screening results and that, if I do not have them at my initial visit, *by signing this consent* I express my desiree to initiate my treatment at Kick Some Mass and give permission to Kick Some Mass and physician, Jeffrey Ruterbusch D.O., to commence treatment without first knowing the results of said screening, and I shall release Kick Some Mass and physician, Jeffrey Ruterbusch D.O., of any claims of liability for prostate cancer, breast cancer, testicular cancer, and/or colon cancer. Further, I agree to immediately notify Kick Some Mass and physician, Jeffrey Ruterbusch D.O., of any abnormal findings on above-noted screenings and supply a copy of any applicable records for their review.

_____ Female Patients: I, _____, agree to obtain and remain up to date on all age appropriate screenings including, but not limited to, colonoscopy, PAP smear, and pelvic exam, mammogram and breast exam, DEXA scan, and cardiac screenings as necessary (stress test, etc.). I agree to obtain these screenings through the appropriate physician(s) (PCP, OBGYN, cardiologist, etc.) and will not hold Kick Some Mass staff, physician Jeffrey Ruterbusch D.O., or health care practitioners responsible or liable for performing these screenings or treatment/managing any abnormal findings relating to these screenings. I acknowledge that Kick

Some Mass would like to be supplied with copies of my current and future screening results and that, if I do not have them at my initial visit, *by signing this consent* I express my desiree to initiate my treatment at Kick Some Mass and give permission to Kick Some Mass and physician, Jeffrey Ruterbusch D.O., to commence treatment without first knowing the results of said screening, and I shall release Kick Some Mass and physician, Jeffrey Ruterbusch D.O., of any claims of liability for prostate cancer, breast cancer, testicular cancer, and/or colon cancer. Further, I agree to immediately notify Kick Some Mass and physician, Jeffrey Ruterbusch D.O., of any abnormal findings on above-noted screenings and supply a copy of any applicable records for their review.

I, _____, understand that it has been more than one year since my last mammogram. The health professionals at Kick Some strongly recommend annual mammograms because we consider these vital in the early detection of breast cancer.

I agree and understand that it is not the responsibility of Kick Some Mass or physician, Jeffrey Ruterbusch D.O., to perform my recommended mammogram screening and breast exam.

I also understand that certain types of breast cancer, **once present**, may be stimulated by estrogen including my own body's estrogen, and taking estrogen therapy with a **present/active** breast cancer may worsen the chances of survival.

I also understand there are possible benefits associated with this therapy but that no guarantee has been made to me regarding outcomes of this treatment. I also understand that the benefits derived from antioxidants therapy and vitamin therapy will cease and those derived from hormone therapy and drugs alter hormone levels will reverse if the therapy is discontinued.

I also understand that if I am female and become pregnant, I should stop the entire protocol immediately and notify my physician (see separate disclaimer and warning). I understand that this hormone therapy is not for the purpose of preventing pregnancy, and that if I become pregnant on this therapy it could present risk to the fetus (unborn child).

## 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 hormones provided to me. I will comply with recommended dose and methods of administration. I also agree to participate in the initial and subsequent hormone testing, as required to safely monitor and treat my hormone levels.

I certify that I am under the regular care of another physician (Primary Care Physician, OBGYN, Urologist, etc.) for all other medical condition. I will consult my physician(s) for any other medical services I may require. I understand that this is a specialized practice. I also understand that I will continue under the care of my other physician(s) for any on-going medical consultation that I may need.

Being aware of all aforementioned facts and notices in this document, and after weighing potential risks vs potential benefits, I elect to commence the aforesaid treatment at Kick Some Mass with physician, Jeffrey Ruterbusch D.O., and assume full liability for any adverse effects that may result from the proposed treatment. I waive any claim in law or equity for redress of any grievance that I may have concerning or resulting from the therapy, except as that claim pertains to grossly negligent administration of the therapy.

I fully understand the nature and purpose of portions of the aforementioned treatment may be considered experimental because of lack of adequate scientific evidence or peer-reviewed publications supporting the underlying premise of bio identical hormone replacement therapy and that such therapy might even be considered by some medical professionals to be medically unnecessary because it is not aimed at treating a particular disease.

I understand that I may suspend or terminate treatment at any time and hereby agree Immediately notify the physician or any desire to suspend or terminate this treatment so that such suspension or termination may be done safely.

**Consent**

I hereby authorize my physician to evaluate and treat the conditions I specified on the above pages (this is a 5-page document). I understand my physician may be assisted by other health care professionals, as necessary, and agree to their participation in my care as it relates to the evaluation and treatment of the conditions this Consent to Treat covers. I certify that I am older than 18 years of age or older, am competent to sign this Consent to Treat, and have done so of my own free will.

_____

Patient Name (please print)

_____

Signature of Patient

_____

Date

_____

Kick Some Mass Signature
(Staff/Physician/Healthcare Practitioner)

_____

Date

Witness Signature: _____ Date: _____

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**BHRT and Pregnancy Disclaimer, Warning, and Patient Agreement (Premenopausal Women)**

_____ I understand that testosterone replacement therapy is not to be used by female patients who are pregnant or trying to become pregnant. I have been counseled on the potential risks of using testosterone replacement therapy during pregnancy, particularly the fact that testosterone usage in pregnant women has sometimes been shown to partially masculinize the external genitalia of a developing female fetus (potentially resulting in enlarged clitoris, ambiguous genitalia, etc.). Furthermore, I understand that I should not take estrogen or progesterone supplementation while pregnant or trying to become pregnant. Pregnancy is a very intricate and delicate hormonal process and any exogenous hormones taken during pregnancy may have a detrimental effect on that process.

_____ With these risks in min, I agree to use a consistent reliable form of contraception while on hormone replacement therapy to reduce the chances of pregnancy. Additionally, I agree to immediately notify Kick Some Mass staff and physician, Dr. Jeffrey Ruterbusch, D.O., if at any time that I am taking BHRT: I decide to attempt to become pregnant, decide to discontinue my hormone replacement therapy.

_____ I acknowledge understanding of the above mentioned disclaimer/agreement and agree to release Kick Some Mass and associated physicians, Dr. Jeffrey, D.O., and healthcare practitioners from any claims of liability for any potential adverse outcomes that may result from my failure to comply with this agreement.

_____ I truthfully state that I am not currently breastfeeding nor will breast feed during administration of any prescribed medication(s) or supplement(s). I understand that it is suggested that I not breast feed after the last dose of medication(s)/nutritional supplement(s) is taken until I have consulted Dr. Jeffrey Ruterbusch, D.O.

_____ If I decide to forgo the advice provided by Kick Some Mass staff and breastfeed while administrating any prescribed medication(s) or supplement(s), I do not hold Kick Some Mass accountable for any harm caused to either myself or infant.

Patient Signature: X _____ Date: _____

Witness Signature: X _____ Date: _____