Patient Treatment Consent Form

Provider Information:

- Provider's Name: _Kudzai Dombo, MD_____
- Clinic Name: __Menopause, Medicine and Mindset_____
- Clinic Address: __4400 W Riverside Dve Suite 110_____
- Contact Number: _818-208-6524_____

Treatment Information: I, [Patient's Name], hereby consent to the following treatments and services provided by [Provider's Name] at [Clinic Name]:

Hormone Replacement Therapy (HRT):

- I understand that HRT involves the administration of hormones to alleviate symptoms associated with menopause.
- I have been informed of the potential benefits, risks, and alternatives to HRT.
- I am aware of the need for regular monitoring and follow-up appointments.

Consent and Authorization: I have had the opportunity to discuss the proposed treatments and services with my provider. I understand the nature and purpose of these treatments, including the potential benefits and risks. I am aware of alternatives to these treatments. I have had the opportunity to ask questions, and my questions have been answered to my satisfaction.

By signing this consent form, I voluntarily authorize and consent to the treatments and services outlined above.

Patient's Initials: _____ Date: _____

Provider's Signature: _____ Date: _____