



Hormone Replacement Therapy Treatment Contract

I have been placed on a customized Hormone Replacement Therapy treatment regimen by my McKinney Family Medicine provider that may consist of Testosterone, HCG, Vitamin B12, Estradiol, Progesterone and other medications administered in the form of pills, troches, injections, creams, gels, patches, implantable pellets, and/or nasal sprays. I agree to comply with the following rules, regulations, and stipulations:

1. I was extensively educated about hormone replacement therapy options including oral pills or troches, nasal sprays, creams, gels, patches, injections, and implanted pellets. I was made aware of the risks vs. benefits of each method. I will make every attempt to maintain absolute compliance with the prescribed regimen.
2. Testosterone is a controlled substance; therefore, I am responsible for my prescriptions and medications. Lost, misplaced, destroyed, or stolen prescriptions or medications will not be replaced without an office visit. I understand that refills will be authorized in the quantity determined by McKinney Family Medicine (MFM) policy. No early refills will be authorized. I will obtain all refills through MFM during regular office hours. No refills will be authorized after-hours, on weekends, or on holidays.
3. I was informed that I will be required to have my labs drawn followed by an office visit every **3 to 6** months depending on my regimen. Failure to comply may result in denial of refills, a lag in the regimen, followed by inaccurate lab results.
4. I was informed that, in addition to regular standard vitamins, I may use a protein supplement, meal replacement supplement, creatine supplement, nitric oxide supplement, and/or amino acid (BCAA) supplement. I will NOT use any other supplements, anabolic steroids, hormones (including HGH), hormone boosters, or other forms of testosterone. Furthermore, I will ONLY obtain my HRT prescriptions from my MFM provider. MFM providers will NOT support, recommend, or condone these behaviors, and if discovered, I will be terminated from the MFM clinic immediately.
5. I will inform my other healthcare providers of this regimen and of the existence of this contract. In the event of an emergency, I will provide this same information to the emergency healthcare providers.
6. Males: I was informed of a possible risk of blood clots, deep venous thrombosis, and pulmonary embolism with Testosterone replacement. I agree that I will take 81mg of enteric-coated aspirin daily with food (or other prescribed anticoagulant medication) in order to reduce these risks unless I am allergic to aspirin, or it is contraindicated. I will also comply with routine blood donation as directed by my MFM provider.
7. If requested, I acknowledge that it is my responsibility to provide prior medical records from my previous healthcare providers to MFM within 90 days.
8. If applicable, I was educated on how to administer home injections in a safe, sterile, and effective manner by MFM staff. I was also counseled on the potential side effects and complications of home injections including hematoma, infection, bruising, pain, and muscle soreness.
9. I acknowledge that I have been counseled on the side effects of the regimen that has been prescribed including but not limited to weight gain, fluid retention, acne, scalp hair loss, facial/body hair growth, mood changes, clitoral/penile enlargement, gynecomastia, lowered sperm counts, infertility and gonadal shrinkage. I have also been counseled on solutions to these side effects should they occur. I will notify McKinney Family Medicine in a timely fashion if these side effects occur and become intolerable or if I should have any questions or concerns.

I have read the above **Hormone Replacement Therapy Treatment Contract** and the **Hormone Replacement Therapy Basics** form that was given to me. I understand that failure to comply with the statements contained within the HRT Contract and HRT Basics constitutes grounds for my family's dismissal from McKinney Family Medicine. I also understand that any suspected abuse reported by or to the clinic staff constitutes grounds for my family's dismissal from McKinney Family Medicine. I have been offered a copy of this signed agreement, and it will remain in effect indefinitely.

Signature: _____

Name: _____ DOB: _____

Date: _____