Renata Teytelbaum MD, AMMGC

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BIO-IDENTICAL HORMONE REPLACEMENT PROGRAM
DISCLOSURE/LIABILITY WAIVER

While numerous safety measures are taken by Renata Teytelbaum MD and my staff, incidental events may occur that are beyond the control of myself or my staff. Within the medical community, there are opposing views with respect to the use of bio-identical hormonal replacement therapies. The use of bio-identical hormones does provide true medical benefits, and is being used at this office to lessen/treat non-life threatening symptoms you have identified as bothersome, undesirable, and frankly unwanted. It is therefore expressly agreed that you are voluntarily participating in this program and all bio-identical hormonal replacement regimens, and the use of any medications and/or supplements is undertaken at your own risk. You are voluntarily participating in this program and assume all risks of injury to yourself that might result. You hereby agree to waive any claims, or rights you might otherwise have to pursue legal remedies from Renata Teytelbaum MD, and her staff, for injury to you on account of involvement in the bio-identical hormone replacement program. You have carefully read this waiver and fully understand that it is a release of liability.

I accept all terms and conditions of this program.

_____ _____

Signature of patient Date

Printed name: _____

MAINTENACE OF PREVENTATIVE MEDICINE AND CANCER SURVEILLANCE

A requirement for acceptance and continuation in the bio-identical hormone replacement program is adherence to routine cancer/prostate screening. You must have routine physical examinations including a PAP, mammogram, prostate examination, PSA testing and any laboratory blood tests ordered. Your signature below indicates that you will comply by obtaining the cancer/prostate screening from your primary care physician within three months of beginning the bio-identical hormone replacement therapy program and the according to current screening guidelines, which can be obtained, and followed with your primary care physician.

I accept all terms and conditions of this program.

_____ _____

Signature of patient Date

Printed name: _____