CENTER FOR MEN'S HEALTH / C4MH
Human Chorionic Gonadotropin (HCG)
Acknowledgment, Consent and Disclosure

1. **This Acknowledgement, Consent and Disclosure** ("Acknowledgement"), made this ____day of_____, 20____, by_____ (Print Name), an individual with a medical condition desiring treatment ("Patient") at Center for Men's Health, a medical office in the state of Florida, by the treating physician at Center for Men's Health (DeRespino, Stahl, Griswold, etc.).

2. **Goals of Medical Treatment.** Treatment of Patient's medical conditions and improvement in Patient's quality of life are the goals of the medical treatment at Center for Men's Health.

3. **Medical Treatment.** During the course of medical treatment, Physician may prescribe medications ("Medications") for the management of Andropause**,** Male hypogonadism, low testosterone, erectile dysfunction (ED), anxiety, stress, anger, depression, sleep disturbances, or other medical conditions as diagnosed and treated from time to time ("Treatment").

4. **Treatment Limitations.** Treatment is limited to Men's Health issue in the specialty field of anti-aging medicine; patient understands that Center for Men's Health physician is not their primary care physician. The physicians at Center for Men's Health limit their practice to restoring testosterone levels to normal levels.

5. **No Guarantees or Assurances Regarding Results from Treatment.** No guarantees or assurances have been made, are being made, or will ever be made to Patient regarding specific results Patient may expect from obtaining Treatment.

6. **FDA "Off Label" use.**
Under FDA guidelines The Center For Men's Health purpose of use for HCG is considered "Off Label". The off label use is allowed by the FDA as a physician's right to prescribe or administer any legally marketed device to a patient for any condition or disease within the legitimate health care practitioner-patient relationship. The Center For Men's Health is not promoting the off label use of HCG

7. **Human Chorionic Gonadotropin (HCG) is NOT prescribed for weight loss.**
The Center For Men's Health physicians are not prescribing HCG as a weight loss supplement. Patient agrees not to use HCG as part of a weight loss program and acknowledges that HCG used in such a program may cause serious medical conditions and even death.

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8. **Adverse Reactions.** Treatment and Medications have the potential to produce side effects in Patient. These adverse reactions may be more significant in some individuals.

8.1 **Side effects of Human Chorionic Gonadotropin (HCG) may include the following:**

Acne	**Less serious side effects may include:**
Enlargement of penis and testes	Headache; Feeling restless or irritable;
Growth of pubic hair	Mild swelling or water weight gain
	Depression; Breast tenderness or swelling

9. **Patient's Responsibility and Adverse Reactions.** Patient has the sole responsibility to report all incidences of significant adverse reactions from Medications or Treatment to Physician. Center for Men's Health and Physician are available during its regular business hours, which are conspicuously posted. If Patient is experiencing significant adverse reactions from Medications, after business hours, Patient shall **IMMEDIATELY** contact the emergency department of Patient's local hospital or call 911.

10. **Treatment:** HCG Treatment is exclusive to active Center For Men's Health TRT patients. Treatment will not be provided unless a clinical need exists. Clinical need determination will be based on one or more of the following; physician consultation, physical examination, current medical history.

11. **Termination of Treatment:** Physicians may terminate patient's treatment without cause by notifying patient in writing 30 days prior to service termination. Physician may terminate treatment with cause without written or prior notice.

12. **Patient's Comprehension of Acknowledgement and Responsibility to Inquire**.

- Patient has read, understands, consents to and accepts this Acknowledgement and has the responsibility to inquire if Patient does not fully comprehend every provision hereof.

By signing below, Patient acknowledges Patient has completely read all two (2) pages and understands, authorizes, consents to, and accepts this Acknowledgement.

Dated this _____ day of _____, 20_____

Patient's Printed Name: _____

Patient's Signature: _____

Witness Signature: _____

Witness Printed Name: _____

*******EXISTING TRT PATIENTS:********
PRIOR TO PHYSICIAN TELEMEDICINE CONSULTATION
PLEASE FAX TO 941-485-8404
OR
SCAN AND E-MAIL TO: C4MHSTAFF@GMAIL.COM