VALLEY WELLNESS CENTER

**RELEASE OF LIABILITY**

I, _____, hereby acknowledge by this statement that I have been fully informed by the health care providers at Dr. Patrick Rhoades of the following:

(1) I consent to the administration of bio-identical hormone replacement (including but not limited to natural thyroid, female/male sex hormones, adrenal, and neurotransmitters) and nutritional supplements prescribed. I acknowledge that no guarantees or assurance have been made with respect to the benefits of these therapies and all such therapies may not be recognized by the FDA. I understand that I will be responsible for administration of the therapies at the prescribed doses or schedule. I have been told about the risks and benefits of hormone replacement therapy and agree to report any perceived adverse reactions or problems that may arise from may therapy. I understand there are possible risks and complications if I do not comply with the recommended doses.

(2) I understand that laboratory testing will be performed to establish my baseline levels and agree to comply with requests for ongoing follow up tests to assure proper monitoring when recommended.

(3) I have been informed that insurance companies my not pay for some or all of my hormone replacement (and/or supplement therapy) and labs.

**Medicare recipients please note:** Medicare does not cover most preventative hormone replacement therapy and laboratory screening services recommended by this program and CVPM and Wellness does not submit Medicare claims for denied service.
I therefore agree to pay all services (including pharmacy and laboratory charges not covered) and that I may not be reimbursed by my insurance company. Payment is due at time of service.

(4) I understand that role of CVPM and Wellness health providers is for hormone replacement therapy/nutritional supplement recommendations only. I agree that I am and will continue to be under the care of my primary care physician for all other medical care.

**(5) I fully understand after my initial consultation, I will no longer be eligible for a refund if I should decide to discontinue services.**

**(6) According to Public Health law, any products, kits or recommended supplements cannot be returned for credit or refund under any circumstances.**

**(7) I fully understand that if I do not cancel any upcoming appointment 72 hours in advance, I will be charged the full fee for the office visit.**

I have read this release of liability form and understand it contents, and signing, I consent to treatment

Signature: _____ Date: _____