



Consent for therapy

I request and consent to the administration of Calmglow therapies and authorize prescriptions by the Calmglow health providers. I acknowledge that there are no guarantees or assurances made with respect to the benefits of these therapies prescribed to me.

I understand that initial hormones levels will be performed on some of the therapies to establish my baseline hormone levels.

I agree to comply with requests for ongoing follow up to assure proper monitoring of my levels when recommended.

I understand that I will be responsible for administering these hormones and therapies prescribed to me. I will conform and comply with the recommended doses and methods of administration. I agree to report any adverse reaction to problems that might be related to my therapies.

I have been told about the risks and benefits of hormone supplement therapy. I understand that there are possible risks and complications with hormone supplementation if I do not comply with the recommended dosages.

I have not been promised or guaranteed any specific benefits from the administration of this therapy.

I understand that the role of the Calmglow providers are for hormone replacement therapy, vitamin / mineral / amino acid therapy, thyroid and iodine evaluation, and adrenal function analysis and therapies only. I agree that I am and will be under the care of another physician for all other medial concerns.

I have been informed that insurance companies may not pay for my therapy testing and supplements. I therefore agree to pay for all services, including laboratory and pharmacy charges myself, with the understanding that I may not be reimbursed by my insurance company.

I have read this consent and understand its' contents. I fully understand what I am signing and herby request and consent to treatment.

Patient Signature

Date: _____