SMART CHOICE
HEALTH AND WELLNESS CLINIC

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Female Testosterone Therapy Consent Form

SINGLE SIGNATURE

PATIENT ACKNOWLEDGMENT

I understand that testosterone therapy is being prescribed to address symptoms such as low libido, fatigue, decreased muscle mass, and reduced overall well-being. I acknowledge that this treatment is individualized and may require adjustments based on my response and lab results.

RISKS & SIDE EFFECTS

I understand potential side effects may include:

- Acne or oily skin
- Increased hair growth
- Hair thinning
- Mood changes
- Voice deepening (rare)

MONITORING

I agree to complete recommended lab work and follow-up visits to ensure safe and effective treatment.

FINANCIAL RESPONSIBILITY

I understand in-office injections are $25 per visit and additional treatments or labs may incur separate costs.

Patient Name _____

Signature _____ **Date** _____