SMART CHOICE
HEALTH AND WELLNESS CLINIC

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Male Testosterone Therapy Consent Form

SINGLE SIGNATURE

PURPOSE OF TREATMENT

I understand that testosterone replacement therapy (TRT) is being prescribed to treat symptoms of low testosterone including low energy, decreased libido, erectile dysfunction, reduced muscle mass, and overall decreased well-being.

RISKS & POTENTIAL SIDE EFFECTS

I understand that possible risks and side effects include:

- Acne or oily skin
- Increased red blood cell count (polycythemia)
- Fluid retention
- Mood changes
- Testicular atrophy
- Suppression of natural testosterone production
- Infertility or decreased sperm production

MONITORING & COMPLIANCE

I agree to complete all recommended lab work and follow-up visits. I understand that ongoing monitoring is required to ensure safe and effective treatment.

FINANCIAL RESPONSIBILITY

I understand that testosterone injections are $45 per visit. Additional labs or services may incur separate costs.

PATIENT ACKNOWLEDGMENT

I acknowledge that I have discussed this treatment with my provider, understand the risks and benefits, and consent to proceed with testosterone therapy.

Patient Name _____

Signature _____ **Date** _____