Wycoff Wellness Center
1226 Michigan Avenue
East Lansing, Michigan 48823
517-333-7270 (phone)
517-333-1801 (fax)
800-471-0255 (toll free)
wycoffwellness.com

WYCOFF WELLNESS CENTER – REQUEST/AUTHORIZATION FOR TREATMENT

I request to be treated by Dr. Wycoff and the Wycoff Wellness Center. I understand that many of the testing and therapies recommend by Dr. Wycoff are on the forefront of medicine. Thus, many of these treatments may not be recognized by conventional medicine or physicians and may not be covered under my medical insurance plan. I understand and agree to the following:

* Bioidentical hormones may be recommended as part of my specific treatment plan. This may include replacement of thyroid hormones, estrogen, progesterone, testosterone, DHEA or cortisol. I understand that these types of treatments may not be recognized or understood by conventional medicine and physicians. All of the medications prescribed by the Wycoff Wellness Center are FDA (Food and Drug Administration) approved. The Wycoff Wellness Center may recommend specific treatments that have not been endorsed by the FDA. The FDA has no specific statement regarding the recommended use of certain bioidentical hormones and approved medications to treat specific illnesses. This allows physicians to use medications for other than approved illnesses for the benefit of the individual patient.

*I understand that conventional medicine and physicians may consider the Wycoff Wellness Center's treatments experimental or may not understand these treatments. There may be other options to treat the unique medical needs such as the use of prescription medications, nutritional changes or surgery.

* I have the right, at any time, not to participate in any portion(s) of the Wycoff Wellness Center's treatment program. I agree to consult with Dr. Wycoff before abruptly stopping any recommended treatment.

* I have the right to request a copy of this treatment consent form. I also have the right to request a copy of my medical records with the appropriate signed medical release of records form. Certain fees may apply to these types of requests.

*I understand that the treatment with bioidentical hormones, including thyroid hormones, estrogen, progesterone, testosterone, DHEA and adrenal hormones may cause side effects. True allergic reactions to these bioidentical hormones are very rare, however side effects may occur. I have been advised to contact the office with any concerns I may have regarding any potential side effects.

*I have been advised that thyroid hormone treatment does not permanently damage my thyroid gland. The following symptoms may be related to excessive thyroid replacement and the need for a dose adjustment:

* Increased pulse rate or palpitations
* Basal body temperature consistently above 98.2 degree orally
* Tremors, nervousness, insomnia or headaches
* Changes in appetite, nausea, diarrhea or unexplained weight loss
* Heat intolerance or other unknown or unrecognized adverse effects
* If you have or develop any type of heart disease, thyroid hormone replacement should be used with caution. This includes angina pectoris, congestive heart failure or coronary artery disease.

* I agree to make my physicians aware of any and all medications that I am taking while under the care of the Wycoff Wellness Center. This includes all prescription medications along with all over the counter medications, vitamins and/or supplements.
* Benefits of the Wycoff Wellness Center's treatments are typically gradual and occur over time. Positive changes may require several cycles of medications or supplement adjustments.
* I understand that some patients may not receive any benefit from the Wycoff Wellness Center's treatments and may have adverse reactions.
* I understand that additional treatments or adjustments may be required to maintain optimal health and wellness.
* Insurance companies may require copies of my medical records to process my claim. By signing below I am authorizing the Wycoff Wellness Center to send my complete medical record to my insurance company once they are requested.
* By signing below, I acknowledge that some physicians may prefer their own course of treatment and may disagree with the treatment(s) chosen by the Wycoff Wellness Center.

I have had an opportunity to read this entire document. I have been given the opportunity to have any and all questions answered to my full and complete understanding and satisfaction. I expressly acknowledge that there has been no guarantee made to me as to the benefits or lack of complications from treatment(s) received. I hereby request treatment from the Wycoff Wellness Center and John O. Wycoff, D.O.

_____ _____

Patient's Signature (Guardian if appropriate) Date

_____ _____

Patient's Printed Name Witness