The Vital Life
19 N. 10th Avenue, Suite 2 · Bozeman, MT 59715
Phone: 406-586-1100 · Fax: 406-403-0500 · drlang@thevitallife.net

# Consent for Hormone Replacement

I request and consent to the administration of hormone replacement therapy and authorize that this will be prescribed by Michael Lang, ND of The Vital Life. I acknowledge that there are no guarantees or assurances made with respect to the benefit of hormone replacement therapy prescribed for me. (Initial) ______

I understand that I will be in charge of administering these hormones and supplements prescribed to me. I will conform and comply with the recommended doses and methods of administration. I understand that with hormone replacement there are possible risks and complications if I do not comply with the recommended dosages. (Initial) ______

I agree to comply with the requests for ongoing testing to assure proper monitoring of my hormone levels. I agree to report to the physician any adverse reaction or problems that might be related to my hormone therapy, such as, but not limited to: vaginal bleeding, breast tenderness, blood clots, and an abnormal result on mammography, ultrasound or other imaging found by·another physician. {Initial) ______

I understand that hormone replacement therapy is controversial and that there are posslble risks with hormone replacement therapy such as, but not limited to, heart attacks, blood clots. stroke, infertility, cancer, and stimulation of pre-existing cancer (including one that has not yet been detected). I understand that cancer could develop while on hormone replacement therapy. I have assessed these risks on a personal basis, and my perceived value of the hormone therapy outweighs the risks. Furthermore, I agree to follow the screening recommendations that the physician at The Vital Life recommends. (Initial). ______

I have been informed that insurance companies and Medicare do not pay for hormone replacement therapy. I therefore agree to pay for all services including laboratory and pharmacy charges myself, with the understanding that I will not be reimbursed by my insurance company. (Initial). ______

I have read and understand all of the above consent. The doctor has reviewed the risks and benefits of hormone replacement with me and I hereby request and consent to treatment using hormone replacement therapy. (Initial) ______

I hereby release and agree to hold harmless Michael Lang, ND, The Vital Life, or its employees from any and all liability, claims. demands, and actions arising or related to any loss, property damage, illness, injury or accident that may be sustained by me as a result of hormone replacement therapy. I acknowledge and agree that I have been given adequate opportunity to review this document and to ask questions. This release and hold harmless agreement is and shall be binding on myself and my heirs, assigns, and personal representatives. (Initial) ______

______________________________________________________________

Patient Printed Name | Signature | Today's Date

______________________________________________________________

Physician Printed Name | Signature | Today's Date

# The Vital Life

## Michael Lang, ND, ABHRT*

**Welcome to my office!**

My health goals for you are to enhance your present level of health while building a strong long-term program to prevent Heart Disease, Osteoporosis, Alzheimer's disease, and potentially, Diabetes and some Cancers.

I encourage you to ask questions to make sure you understand what I do. I practice evidence-based medicine based on good, sound, credible research. I seek to make information available to you so we can be on the same page.

Your safety will always be my first concern. Secondarily are the short and long term benefits for you.

I only do preventative medicine so it is expected that you continue your disease care with your family doctor and your health maintenance team.

Payment is expected at time of service. I do not accept insurance assignment. At the time of service, I will provide you with a super bill that you may submit from me as an out of network provider. If payment is not possible at the time of service, it is important we talk before the service.

**Patient fees (as of January 1, 2020):**

- **$900.00 Vital Life Bio-identical Hormone Program, first year of service**
- **$300.00 Subsequent years service ongoing**
- **$165.00 Acute care, non Vital Life care, first thyroid only visit**
- **$90.00 Follow up visits for acute care etc., non Vital Life**

**Please sign below, indicating that you have read and understand the above statements.**

________________________________________ ______________________

Name Date

________________________________________

Childs' name (if parent or guardian signs to give permission for treatment)

*ABHRT=Advanced Bio Identical Hormone Replacement Therapy

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Michael Lang
Naturopathic Physician
406.586.1100 Fax: 406.403.0500

The Vital Life
19 North 10th Ave
Bozeman, MT 59715

# Patient Profile Intake Form

By completing this profile of your health history, I can offer you more complete naturopathic care. Please be assured that I keep this information confidential.

Name ______________________ Age ________ Birth Date ______________
Address ______________________ City ______________ State ______ Zip ________
Home Phone ______________ Work Phone ______________ Cell Phone ______________
Email Address ______________________________________________

Married  Partnered  Separated  Divorced  Widowed  Single  Children? Yes / No

How did you hear about us? ______________________________________________

Where, when, from who, and for what reason did you last receive any healthy care?

______________________________________________

______________________________________________

______________________________________________

Please list, in order of importance, you health concerns and/or goals.

1. ______________________________________________
2. ______________________________________________
3. ______________________________________________
4. ______________________________________________

**Family Health History:** Y=Yes N=No D=Caused Death (age of death) P=in the past
Please indicate if a family member has had any of the following. If yes, please specify who.

| | | | | | |
|---|---|---|---|---|---|
| Anemia | Y | N | D | P | ______________ |
| Arthritis | Y | N | D | P | ______________ |
| Asthma / Hay Fever | Y | N | D | P | ______________ |
| Cancer (type?) | Y | N | D | P | ______________ |
| Cystic Fibrosis | Y | N | D | P | ______________ |
| Diabetes | Y | N | D | P | ______________ |
| Eating Disorder | Y | N | D | P | ______________ |
| Epilepsy | Y | N | D | P | ______________ |
| Fibromyalgia | Y | N | D | P | ______________ |
| Glaucoma | Y | N | D | P | ______________ |
| Heart Disease (incl heart attacks) | Y | N | D | P | ______________ |
| Hypertension (high blood pressure) | Y | N | D | P | ______________ |
| Kidney Disease | Y | N | D | P | ______________ |
| Mental Illness | Y | N | D | P | ______________ |
| Lung Disease | Y | N | D | P | ______________ |
| Stroke | Y | N | D | P | ______________ |
| Substance Abuse | Y | N | D | P | ______________ |
| Venereal Disease | Y | N | D | P | ______________ |

**Blood Type (please circle) A B AB O**

**Allergies:**

Drugs: ______________________________

Food: ______________________________

Environmental: ______________________________

**Have you ever been hospitalized?** Please list when and why.

Illnesses: ______________________________

Surgeries: ______________________________

Other: ______________________________

**Medications:** Please indicate if you have used any of the following.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Appetite suppressants | Y | N | P | Sleeping pills | Y | N | P |
| Antacids | Y | N | P | Pain relievers | Y | N | P |
| Birth control pill or implant | Y | N | P | Other hormones | Y | N | P |
| Thyroid medicine | Y | N | P | Tranquilizers | Y | N | P |
| Laxatives | Y | N | P | Cortisone | Y | N | P |

Please list current prescription drugs, over-the-counter drugs, vitamins, herbs, or other supplements and the reason for taking them. ______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

## Consent to Naturopathic Treatment Provided by Michael Lang, ND

1. This is to acknowledge that I have been informed and understand that:

   a) Any treatment or advice provided to me as a patient of Michael Lang, ND is not mutually exclusive from any treatment or advice that I may be receiving nor or in the future, from another health care provider.

   b) I am at liberty to seek or continue medical care from a physician, surgeon, or other health care provider.

   c) I understand that Michael Lang, ND is not preventing me from seeking or following the advice of another licensed health care provider.

   d) The treatment and therapies provided to me by Michael Lang, ND may be different from those offered by another licensed health care provider.

2. I agree to pay for any fees for services, costs of supplements and homeopathic remedies, cost of laboratory tests, or other fees at the time of the visit.

3. I hereby authorize and consent to treatment.

______________________________ ______________________________

Patient Signature Date