Female New Patient Package

Whether you are a new patient interested in the benefits of advanced hormone replacement therapy or an existing patient who is interested in improving your **Quality of Life**, we look forward to speaking with you and evaluating whether or not BioTE pellet therapy may be right for you.

Please take the time to read this introductory packet and answer the questions as completely as possible. Pay particular attention to the **Symptom Assessment Checklist**, as it's important that our office understands the symptoms you may be experiencing today, and to what degree, so that we can approach your individual treatment plan, accordingly. Additionally, please take a BioTE brochure from our reception area or exam room and visit www.BHRTVideos.com to learn more.

To determine if you are a candidate for bio-identical hormone replacement pellet therapy, we will need the following:

- ☐ Updated Laboratory Values = 1st Step in the treatment process (ask our office how)
- ☐ Updated Medical History
- ☐ Completed **Symptom Assessment Checklist**

Your advanced hormone lab panels may take approximately 2 weeks to be received by our office. We will then schedule an office visit (consult) to review your lab panels, medical history and symptom checklist, and of course address questions you may have about advanced hormone replacement pellet therapy. If you are a candidate and decide to move forward with BioTE therapy, we will most likely be able to perform the very simple and painless procedure in just a few minutes in our office that same day.

Your blood work panel MUST include the following tests:

___Estradiol
___FSH
___Testosterone, Total
___TSH
___T4, Total
___T3, Free
___T.P.O. Thyroid Peroxidase Antibodies
___Vitamin D, 25-Hydroxy
___Vitamin B12
___CBC (Complete Blood Count)
___CMP (Comprehensive Metabolic Panel)
___ Homocysteine

Female Post Insertion Labs Needed at 6 weeks:

___FSH
___Testosterone, Total
___Estradiol
___TSH, T4 Total, T3 Total (**Needed only if you've been prescribed thyroid medication at visit**

Female Patient Questionnaire & History

Name:_____ Today's Date: _____
(Last) (First) (Middle)

Date of Birth:_____ Age:_____ **Weight:**_____ Profession:_____

Home Address: _____

City:_____ State:_____ Zip: _____

Home Phone:_____ Cell Phone:_____ Work: _____

E-Mail Address:_____ May we contact you via E-Mail? ( ) **YES** ( ) **NO**

In Case of Emergency Contact:_____ Relationship: _____

Home Phone:_____ Cell Phone:_____ Work: _____

Primary Care Physician's Name:_____ Phone: _____

Address: _____
Address City State Zip

Marital Status (check one): ( ) Married ( ) Divorced ( ) Widow ( ) Living with Partner ( ) Single

In the event we cannot contact you by the mean's you've provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are **giving us permission** to speak with your spouse or significant other about your treatment.

Spouse's Name:_____ Relationship: _____

Home Phone:_____ Cell Phone:_____ Work: _____

Insurance: Insured Name:_____ DOB:_____ SS#_____

Relation to Patient:_____ Employer:_____ Primary Insurance:_____

Claims Address:_____ City/State/Zip_____

ID#_____ Group#_____

Social History:

( ) I smoke cigarretes/cigars/vape
( ) I am sexually active
( ) I have completed my family

Medical History

Any known **drug/environmental (i.e. tape/adhesive) allergies**: _____

Have you ever had any issues with anesthesia? ( ) Yes ( ) No
If yes please explain: _____

Medications Currently Taking: _____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Nutritional/Vitamin Supplements: _____

Surgeries, list all and when: _____

Last menstrual cycle (estimate year if unknown): _____

Other Pertinent Information: _____

Preventative Medical Care:

Date of last pap smear:_____

Was it normal? Y N

Date of last Mammogram:_____

Was it normal? Y N

Do you have a history of:

( ) Breast Cancer
( ) Uterine Cancer
( ) Ovarian Cancer
( ) None of Above

Have you had:

( ) Hysterectomy with removal of ovaries.
( ) Hysterectomy (removal of uterus only)
( ) Oophorectomy (Removal of Ovaries only)

Birth Control Method:

( ) Menopause
( ) Hysterectomy
( ) Tubal Ligation
( ) Birth Control Pills
( ) Vasectomy

Please mark any **Medical Illnesses:**

( ) High blood pressure
( ) High cholesterol.
( ) Uterine Fibroids
( ) Polycystic Ovarian Syndrome (PCOS)
( ) Stroke and/or heart attack.
( ) Heart Bypass/Heart Disease
( ) Blood clot and/or a pulmonary emboli
( ) Arrhythmia/Irregular Heartbeat
( ) Any form of Hepatitis or HIV
( ) Lupus or other Autoimmune disease
( ) Fibromyalgia
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis)
( ) Seizure Disorder/Epilepsy
( ) Chronic Kidney Disease
( ) Diabetes
( ) Thyroid disease
( ) Arthritis
( ) Depression/anxiety
( ) Cancer (type): _____ & Year _____

Female Testosterone and/or Estradiol Pellet Insertion Consent Form

Name:_____ Today's Date:_____

(Last) (First) (Middle)

Pellets are bioidentical, structurally equivalent to the hormones your body naturally produces. Estrogen and testosterone are made in your ovaries and adrenal glands. Even prior to menopause, testosterone levels start to decrease. Bio-identical hormones have the same effects on your body as your own naturally occurring hormones did when you were producing them at adequate levels. Bio-identical hormone pellets are plant derived and are FDA monitored but not FDA approved for female hormone replacement. The pellet method of hormone replacement has been used in Europe and Canada for many years and by select practitioners in the United States.

Patients who are pre-menopausal are advised to **continue reliable birth control** while participating in pellet hormone replacement therapy. Testosterone is category X (could cause birth defects based on human/animal studies) and should not be given to pregnant women.

My birth control method is: (please circle)

Abstinence Birth control pill Hysterectomy IUD Menopause Tubal ligation Vasectomy Other

CONSENT FOR TREATMENT: I consent to the insertion of testosterone and/or estradiol pellets in my hip/abdomen. I have been informed that I may experience any of the complications to this procedure as described below. **Surgical risks are the same as for any minor medical procedure and are included in the list of overall risks :** Bleeding, bruising, swelling, infection and pain; extrusion of pellets; hyper sexuality (overactive Libido); lack of effect (from lack of absorption); breast tenderness and swelling; increase in hair growth on the face; acne; water retention; increased growth of estrogen dependent tumors (endometrial cancer, breast cancer); birth defects in babies exposed to testosterone during their gestation; change in voice (which is reversible); clitoral enlargement (which is reversible). The estradiol dosage that I may receive can aggravate fibroids or polyps, if they exist, and can cause bleeding. Testosterone therapy may increase one's hemoglobin and hematocrit. This elevation can be seen with a blood test. Thus, a complete blood count should be done at least annually. This condition can be reversed simply by donating blood periodically.

BENEFITS OF TESTOSTERONE PELLETS INCLUDE: Increased libido, energy, and sense of well-being. Increased muscle mass and strength and stamina. Decreased frequency and severity of migraine headaches. Decrease in mood swings, anxiety and irritability. Decreased visceral fat. Decrease in risk or severity of diabetes. Decreased risk of heart disease. Decreased risk of Alzheimer's and dementia

BENEFITS OF ESTRADIOL PELLETS INCLUDE: Decreased vaginal dryness. Increased skin elasticity. Decreased hot flashes, mood swings, depression, anxiety, and headaches caused by hormone fluctuations. Increase and maintenance of bone density. May prevent atherosclerosis (hardening and narrowing of the blood vessels) and complications associated with coronary artery disease. Decrease risk of Alzheimer's and dementia (neuroprotection).

I have read and understand the above. I have been encouraged and have had the opportunity to ask any questions regarding pellet therapy. All of my questions have been answered to my satisfaction. I further acknowledge that there may be risks of testosterone and or estrogen therapy that we do not yet know, at this time, and that the risks and benefits of this treatment have been explained to me and I have been informed that I may experience complications, including one or more of those listed above. I accept these risks and benefits and I consent to the insertion of hormone pellets under my skin. This consent is ongoing for this and **all future pellet insertions**.

I understand that payment is due in full at the time of service. I also understand that it is my responsibility to submit a claim to my insurance company for possible reimbursement. I have been advised that most insurance companies do not consider pellet therapy to be a covered benefit and my insurance company may not reimburse me, depending on my coverage. I acknowledge that my provider has no contracts with any insurance company and is not contractually obligated to pre-certify treatment with my insurance company or answer letters of appeal.

_____ _____

Print Name **Signature** **Today's Date**

INSTITUTE for HORMONAL BALANCE

Female Symptom Assessment Checklist

Name: _____ **Date:** _____

Symptom (please check mark)	Never	Mild	Moderate	Severe
Depressive mood				
Anxiety				
Memory Loss /brain fog				
Decreased sex drive/libido				
Difficult to climax sexually				
Sleep problems				
Mood changes/Irritability				
Fatigue				
Migraine/severe headaches				
Weight gain				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and Wrinkled Skin				
Hair is Falling Out				
Cold all the time				
Joint pain				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Breast Cancer		

Hormone Replacement Fee Acknowledgment

You will be responsible for payment in full at the time of your procedure. Although more insurance companies are reimbursing patients for the BioTE® Medical Hormone Replacement Therapy, there is no guarantee.

We will give you paperwork to send to your insurance company to file for reimbursement upon request.

New Patient Consult Fee	**$125**
Female Hormone Pellet Insertion Fee	**$330**
Male Hormone Pellet Insertion Fee	**$625**
Male Pellet Insertion Fee (>2000mg)	**$725**

We accept the following forms of payment:

Master Card, Visa, Discover, American Express, Personal Checks, HSA, FSA, and Cash.

Print Name **Signature** **Today's Date**

Hormone Therapy Dosing Assistance Form

Name:_____

Weight: _____ DOB:_____

Last 4 SSN:_____

Medical History:

	Yes	No
Hysterectomy		
Breast Cancer		
Still Menstruating		
Currently on Thyroid Medication		
Hashimoto's Thyroiditis		
Fibrocystic Breast Disease		
PCOS		
Migraine Headaches		
History of Fibroids/Polyps		
Epilepsy		
Currently on HRT		
Currently Pregnant/Trying to Conceive		
Currently on Birth Control		

Are you having any of the following Symptoms?

	Yes	No
Acne		
Irregular Bleeding		
Heavy Bleeding		
Facial Hair		
Breast Tenderness		

Social History:

How often do you exercise? (Circle)

0hrs	1-3hrs/wk	4-7 hrs/wk	>8 hrs/wk

Do you smoke?

Yes	No

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Print Name **Signature** **Today's Date**

Patient Portal Authorization Form

Print Patient Name:_____ Date of Birth:_____

Personal Email Address(please print clearly):_____ (Please supply the personal email address and photo ID of the person who will be using the patient portal. If you do not have an email address please indicate so and put patient's first name and last name.)

Purpose of this Form:
The Patient portal offers patients a secure way for our staff to email parts of your medical records and communicate with you regarding records, lab results and next step of care.

How to Participate in the Patient Portal:
To participate, please provide a copy of your photo ID and this signed form. Once we have processed your info you will be given a login and temporary password.

Protecting Your Private Health Information and Risks:
Keeping health information secure depends on two important factors: we need you to make sure we have your correct email address and you must inform us if it ever changes. We strongly suggest that you use a personal email account rather than a work email address as this information might be available to your employer.

Conditions of Participating in the Patient Portal:
We understand the importance of privacy with regard to your health care and will continue to protect the privacy of your medical information. Our use and disclosure of medical information is described in our Notice of Privacy Practices. Access to this secure web portal is an optional service, and we may suspend or discontinue it at any time for any reason. If we do, we will notify you as promptly as possible. As a user of the patient portal and by signing this form you agree NOT to:

1. Transmit any electronic information that violates the rights of privacy of any party.
2. Use the web portal in any way that would violate local, state or federal laws.
3. Transmit materials that are obscene, defamatory, abusive, slanderous or otherwise likely to harm others.
4. Intentionally distribute computer viruses or take any other action to compromise security of our system.

( ) YES I want to enroll in the patient portal ( )NO I do not want to enroll in the patient portal

Patient/Responsible/Legal Guardian Acknowledgement:

Signature:_____ Date:_____

Permission to Disclose Personal Medical Information

Please provide us with the telephone number you would like us to use when contacting you with regards to medical records, such as test results, treatment options, etc.

Patient Name:_____Date of Birth: _____

PrimaryPhoneNumber:_____Secondary Phone Number: _____

Voice Mail Messages: (check one)

O Confidential information may not be left on voice mail.

O I give permission for the Institute for Hormonal Balance staff members to leave messages, with discretion, on voice mail for the numbers listed above.

Disclosure to Other Persons: (check one)

O Any information regarding my health record or treatment options may only be discussed withme.

O I give permission Institute for Hormonal Balance staff members to disclose health information to the following people:

1._____Relationship _____Phone:_____

2. _____Relationship _____Phone:_____

3. _____Relationship _____Phone:_____

I understand that the release of information may be electronic, written or verbal and that this consent form will remain in effect until a written request for revocation is received by our office. The Institute for Hormonal Balance staff members reserve the right, at our discretion, to limit the disclosure of medical information to additional parties (such as family members) unless we have a signed copy of this form on file.

_____

Signature Date