Male 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 **Patient Symptom Assessment**, 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 rooms 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 Health Assessment Symptom 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.

2 weeks prior to your scheduled consult appointment: Have your blood labs drawn. Please ask our office where to get these performed. We do request the specific initial **MALE** lab panels listed below for your advanced hormone replacement therapy blood work:

Your blood work panel MUST include the following tests:

___ Estradiol
___ Testosterone Free & Total
___ PSA, Total
___ TSH
___ T4, Total
___ T3, Free
___ T.P.O. Thyroid Peroxidase
___ CBC
___ Vitamin D, 25-Hydroxy
___ CMP
___ Vitamin B12
___ Homocysteine

Male Post Insertion Labs Needed at 4 Weeks:

___ Estradiol
___ Testosterone Free & Total
___ PSA Total (If PSA was >2.5 on first insertion)
___ CBC
___ TSH, T4 Total, T3 Free, TPO (**Only needed if you've been prescribed thyroid medication**)

Male 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: _____

Social History:

( ) I am sexually active.
( ) I have completed my family.
( ) I am trying to conceive.
( ) I have used steroids in the past for athletic purposes.
( ) I smoke (cigarettes or cigars) _____ a day.
( ) I drink alcoholic beverages _____drinks, _____times per week.
( ) I use caffeine _____cups per day.

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: _____

Other Pertinent Information: _____

Medical History:

( ) High blood pressure.
( ) High cholesterol.
( ) Heart Disease.
( ) Stroke and/or heart attack.
( ) Blood clot and/or a pulmonary emboli.
( ) Hemochromatosis.
( ) Depression/anxiety.
( ) Psychiatric Disorder.
( ) Cancer (type): _____
Year: _____

( ) Testicular or prostate cancer.
( ) Treated _____-(Date)
( ) Elevated PSA.
( ) Prostate enlargement.
( ) Trouble urinating or taking Flomax or Avodart.
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis).
( ) Diabetes.
( ) Thyroid disease.
( ) Arthritis.

I understand that if I begin testosterone replacement with any testosterone treatment, including testosterone pellets, that I will produce less testosterone from my testicles and if I stop replacement, **I may experience a temporary decrease in my testosterone production which includes decreased sperm production.** Testosterone Pellets should be completely out of your system in 12 months. **Therefore I should not be on testosterone therapy if I am actively trying to conceive**.

By beginning treatment, I accept all the risks of therapy stated herein and future risks that might be reported. I understand that higher than normal physiologic levels may be reached to create the necessary hormonal balance.

_____

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

Male Patient Symptom Assessment

Name: _____ **Date:** _____

Symptom *(please check mark)*	Never	Mild	Moderate	Severe
Decline in general well being				
Joint pain/muscle ache				
Sleep problems				
Increased need for sleep				
Irritability				
Anxiety				
Depressed mood				
Fatigue/Decreased Stamina				
Declining Mental Ability/Focus/Concentration				
Decreased muscle strength/ability to build muscle				
Weight Gain/Belly Fat/Inability to Lose Weight				
Hair Loss				
Migraine or frequent Headaches				
Decreased desire/libido				
Decreased morning erections				
Decreased ability to perform sexually or Climax				
Infrequent or Absent Ejaculations				
No Results from E.D. Medications				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		

Male Hormone Therapy Dosing Assistance Form

Name: _____ Weight: _____DOB:_____Last 4 SSN:_____

Medical History:

	Yes	No
Prostate Cancer		
Prostate Cancer Treated?		
Recent Urologic Workup		
BPH/Prostatitis		
Currently on Thyroid Medication		
Hashimoto's Thyroiditis		
Migraine Headaches		
Currently on HRT		
Currently Trying to Conceive or contemplating conception		

Social History:

How often do you exercise? (circle)

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

Do you smoke?

Yes	No

Testosterone Pellet Insertion Consent Form

Bio-identical testosterone pellets are concentrated, compounded hormone, biologically identical to the testosterone that is made in your own body. Testosterone starts decreasing in our late 20s and early 30s. Bio-identical hormones have the same effects on your body as your own testosterone did when you were producing it at adequate levels. Bio-identical hormone pellets are plant derived and pellets have been used in Europe, the U.S. and Canada since the 1930's. Your risks are similar to those of any testosterone replacement. When the body stops producing adequate levels of testosterone, the risk of not receiving adequate hormone therapy can outweigh the risks of restoring levels to optimal levels.

Risks/Symptoms of low testosterone include but are not limited to:
Arteriosclerosis (hardening of the blood vessels), elevation of cholesterol, obesity, loss of strength and stamina, osteoporosis, anemia, depression, anxiety, worsening of arthritis or joint pain, loss of libido, erectile dysfunction, loss of skin and muscle tone, insulin resistance, increased inflammation in the body, dementia and Alzheimer's disease.

CONSENT FOR TREATMENT: I consent to the insertion of testosterone 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.**

Side effects may include:
Bleeding, bruising, swelling, infection and pain and possible extrusion of pellets. Lack of effect (From lack of absorption). Thinning hair, male pattern baldness. Acne, Hyper sexuality (overactive libido). Ten to fifteen percent shrinkage in testicle size. There can also be a significant reduction in sperm production.

A prostate specific antigen blood test is to be done before starting testosterone pellet therapy and will be conducted each year thereafter based on recommendations. Based on results of the PSA, an ultrasound of the prostate gland may be required as well as a referral to a qualified specialist. While urinary symptoms typically improve with testosterone, rarely they may worsen, or worsen before improving. Testosterone therapy may increase one's hemoglobin and hematocrit. This elevation can be diagnosed with a blood test. Thus, a complete blood count should be done at least annually. This condition can be reversed 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 (secondary to hormonal decline). Decreased weight (Increase in lean body mass). Decrease in risk or severity of diabetes. Decreased risk of Alzheimer's and Dementia. Decreased risk of heart disease in men less than 75 years old with no pre-existing history of heart disease.

On January 31, 2014, the FDA issued a Drug Safety Communication indicating that the FDA is investigating risk of heart attack and death in some men taking FDA approved testosterone products. The risks were found in men over the age of 65 years old with pre-existing heart disease and men over the age of 75 years old with or without pre-existing heart disease. These studies were performed with testosterone patches, testosterone creams and synthetic testosterone injections and did not include subcutaneous hormone pellet therapy.

I agree to immediately report to my practitioner's office any adverse reactions or problems that may be related to my therapy. Potential complications have been explained to me and I agree that I have received information regarding those risks, potential complications and benefits, and the nature of bio-identical and other treatments and have had all my questions answered. Furthermore, I have not been promised or guaranteed any specific benefits from the administration of bio-identical therapy. I certify this form has been fully explained to me, and I have read it or have had it read to me and I understand its contents. 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 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 if I desire. 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**

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**

Hormone Replacement Fee Acknowledgment

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

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 (≥2100mg)	**$725**

We accept the following forms of payment:

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

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