Male New Patient

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 is 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**

We will first order a blood work panel (may take approximately 2 weeks for results to be received by our office) and schedule your office consult. **We must have your lab results PRIOR to your consult appointment.** At your consult we will review your blood work, 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 procedure in just a few minutes in our office that same day. We will file an office visit with your insurance and your specialist copay will be due at that time. Please note, it is your responsibility to make sure Dr. Gary Donovitz is an in-network provider with your individual insurance plan. If you do not have insurance or have a high deductible, you will owe $125 for your consultation visit and if a referral is needed for a specialist visit, you will be responsible for obtaining the referral prior to your appointment.

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 Antibodies
___ CBC (Complete Blood Count)
___ Vitamin D, 25-Hydroxy
___ CMP (Comprehensive Metabolic Panel)

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:____Date:____________
(Last) (First) (Middle)

Date of Birth:______________ Age:________ Weight:____________ Last four SS#:_________________________

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

INSURANCE:

Insured Name:____DOB:____________SS#___________________

Relation to Patient:_________Employer:__________Primary Insurance:__________________________________

Claims Address:____________________________________City/State/Zip________________________________

ID#____Group#__________________________________

SOCIAL HISTORY:

( ) I smoke cigarettes/cigars/vape
( ) I am sexually active
( ) I have completed my family
( ) I am trying to conceive
( ) I have used steroids in the past for athletic purposes

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 Symptom Assessment Checklist

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 FOUR 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?

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

Do you smoke?

Yes	No

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: ________________________

Primary Phone Number:__________________________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 with me.

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 reserves 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.

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Signature **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

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 (>2100mg)	**$725**

We accept the following forms of payment:

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

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

Cancellation/No Show Policy

1. **CANCELLATIONS**

   We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Also the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment schedule.

   If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar ($50) fee.

2. **NO SHOWS**

   Patients who do not show up for their appointment and do not call to cancel their appointment will be considered a NO SHOW. Patients who NO SHOW two (2) or more times in a 12 month period, may be dismissed from the practice and they will be denied any future appointments.

   If you are a NO SHOW to your appointment you will be charged a fifty dollar ($50) fee.

3. **LATE APPOINTMENTS**

   We understand that delays can happen however we must try to keep the other patients and doctors on time. If you are 15 minutes or more past your scheduled appointment time you will be asked to reschedule.

   The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

Please sign if you understand and agree.

____

Patient Name (Please print)

____

Signature of Patient or Representative Date