Female 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. Mandy Cotten, FNP-C, PA 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
___ FSH
___ Testosterone, Total
___ TSH
___ T4, Free
___ T3, Free
___ CMP (Comprehensive Metabolic Panel)
___ CBC (Complete Blood Count)
___ Vitamin D, 25-Hydroxy
___ Vitamin B12
___ T.P.O. Thyroid Peroxidase Antibodies

Female Post Insertion Labs Needed at 6 weeks:

___ FSH
___ Testosterone, Total
___ Estradiol
___ TSH, T4 Free, T3 Free (Only needed if you've been prescribed thyroid medication)

Female Patient Questionnaire & History

Name: _____ Date: _____

Date of birth: _____ Age: _____ Weight: _____ Occupation: _____

Home address: _____

City: _____ State: _____ ZIP: _____

Home phone: _____ Cell phone: _____ Work: _____

Preferred contact number: _____

May we send messages via text regarding appts to your cell? ☐ 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: _____ SSN: _____

Relationship to patient: _____ Employer: _____

Primary ins: _____ Claim address: _____

ID #: _____ Group #: _____

Medical History

Social:

☐ I am sexually active. OR ☐ I want to be sexually active. ☐ I do not want to be sexually active.

☐ I have completed my family. OR ☐ I have NOT completed my family.

☐ My sex life has suffered. OR ☐ I have not been able to have an orgasm or it is very difficult.

Habits:

☐ I smoke cigarettes or cigars _____ per day. ☐ I use e-cigarettes _____ per day. ☐ I use caffeine _____ per day.

☐ I drink alcoholic beverage _____ per week. ☐ I drink more than 10 alcoholic beverages a week.

Allergies:

Drug/Environmental allergies: _____ If yes, please explain: _____

Have you ever had any issues with local anesthesia? ☐ Yes ☐ No Do you have latex allergy? ☐ Yes ☐ No

Medication history:

Medications currently taking: _____

_____

Nutritional/Vitamin Supplements: _____

_____

Current hormone replacement? ☐ Yes ☐ No If yes, what? _____

Past hormone replacement therapy: _____

Medical/Surgical history:

☐ Breast cancer
☐ Uterine cancer
☐ Ovarian cancer
☐ Polycystic ovarian syndrome/ PCOS
☐ Acne
☐ Excess facial/body hair
☐ Infertility
☐ Endometriosis
☐ Epilepsy or seizures
☐ Fibrocystic breast or breast pain
☐ Uterine fibroids
☐ Irregular or heavy periods
☐ Menstrual migraines
☐ Hysterectomy with removal of ovaries
☐ Partial hysterectomy (uterus only)
☐ Ophorectomy (removal of ovaries only)
☐ Other Surgeries:_____
_____

Medical History (continued)

Family history:

☐ Heart Disease ☐ Diabetes ☐ Osteoporosis ☐ Alzheimer's/dementia ☐ Breast cancer ☐ Other: _____

Birth control method:

☐ Menopause
☐ Hysterectomy
☐ Tubal ligation
☐ Birth control pills
☐ Vasectomy
☐ IUD
☐ Infertility
☐ Other: _____

Last menstrual period (estimate year if unknown): _____

Medical Illnesses:

☐ High blood pressure or hypertension
☐ Heart disease
☐ Atrial fibrillation or other arrhythmia
☐ Blood clot and/or pulmonary embolism
☐ Depression/anxiety
☐ Chronic liver disease (hepatitis, fatty liver, cirrhosis)
☐ Arthritis
☐ Hair thinning
☐ Sleep apnea
☐ High cholesterol
☐ Stroke and/or heart attack
☐ HIV or any type of hepatitis
☐ Hemochromatosis
☐ Psychiatric disorder
☐ Thyroid disease
☐ Diabetes
☐ Lupus or other autoimmune disease
☐ Other: _____
_____

Wellness Screening:

Date of last pap smear: _____ Was it Normal? ☐ Yes ☐ No

Date of last Mammogram: _____ Was it Normal? ☐ Yes ☐ No

INSTITUTE for HORMONAL BALANCE

Female Patient Symptom Assessment Checklist

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark "none".

Symptoms	None (0)	Mild (1)	Moderate (2)	Severe (3)	Very Severe (4)
Hot flashes					
Sweating (night sweats or increased episodes of sweating)					
Sleep problems (difficulty falling asleep, sleeping through the night or waking up too early)					
Depressive mood (feeling down, sad, on the verge of tears, lack of drive)					
Irritability (mood swings, feeling aggressive, angers easily)					
Anxiety (inner restlessness, feeling panicky, feeling nervous, inner tension)					
Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation)					
Sexual problems (change in sexual desire, sexual activity, orgasm and/or satisfaction)					
Bladder problems (difficulty in urinating, increased need to urinate, incontinence)					
Vaginal symptoms (sensation of dryness or burning in vagina, difficulty with sexual intercourse)					
Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)					
Difficulties with memory					
Problems with thinking, concentrating or reasoning					
Difficulty learning new things					
Trouble thinking of the right word to describe persons, places or things when speaking					
Increase in frequency or intensity of headaches or migraines					
Hair loss, thinning or change in texture of hair					
Feel cold all the time or have cold hands or feet					
Weight gain or difficulty losing weight despite diet and exercise					
Dry or wrinkled skin					
Total score:					

Severity score: Mild: 1-20 / Moderate: 21-40 / Severe: 41-60 / Very severe: 61-80

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.

Name: _____ Date of birth: _____

Primary phone number: _____ Secondary phone number: _____

Voice mail messages (check one):

- ○ Confidential information may not be left on voice mail.
- ○ 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):

- ○ Any information regarding my health record or treatment options may only be discussed with me.
- ○ 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.

_____

Signature **Date**

Acknowledgement of Receipt of Notice of Privacy Practices

"You May Refuse to Sign This Acknowledgement"

I, _____ have been informed of this office's Notice of Privacy Practices.

_____
Print Name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ○ Individual refused to sign
- ○ Communications barriers prohibited obtaining the acknowledgment
- ○ An emergency situation prevented us from obtaining acknowledgement
- ○ Other (please specify): _____

  _____

  _____

Hormone Replacement Fee Acknowledgment & Insurance Disclaimer

Preventative medicine and bioidentical hormone replacement is a unique practice and is considered a form of alternative medicine. Even though the physicians and nurses are board certified as medical doctors, nurses, nurse practitioners and/or physician assistants, insurance does not recognize bioidentical hormone replacement as necessary medicine BUT rather more like plastic surgery (aesthetic medicine). Therefore, bioidentical hormone replacement is not covered by health insurance in most cases.

Insurance companies are not obligated to pay for our services (consultations, insertions or pellets, or blood work done through our facility). We require payment at time of service and, if you choose, we will provide a form to send to your insurance company with a receipt showing that you paid out of pocket. WE WILL NOT, however, communicate in any way with insurance companies.

This form and your receipt are your responsibility and serve as evidence of your treatment. We will not call, write, pre-certify, appeal nor make any contact with your insurance company. If we receive a check from your insurance company, we will not cash it but will return it to the sender. Likewise, we will not mail it to you. We will not respond to any letters or calls from your insurance company.

For patients who have access to Health Savings Account, you may pay for your treatment with that credit or debit card. Some of these accounts require that you pay in full ahead of time, however, and request reimbursement later with a receipt and letter. This is the best idea for those patients who have an I as an option in their medical coverage. It is your responsibility to request the receipt and paperwork to submit for reimbursement.

Consult Fee ..... $ 125.00

Female Hormone Pellet Insertion Fee ..... $ 350.00

We accept the following forms of payment:

MasterCard, VISA, American Express, Discover, cash, check, HSA, FSA

_____

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.

I acknowledge that I have received a copy and understand the instructions on this form.

_____

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 **Today's date**

Patient Portal Authorization Form

Print patient name: _____ Date of birth: _____

Personal email address: _____
(please print clearly)

OR ☐ Please use first and last name (check if applicable)

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, or do not want to provide an email address, please indicate so and provide the first name and last name to be used as the username.

Purpose of the Patient Portal:

The Patient portal offers our patients a secure way to update demographic information, access and print medical records/lab results and the opportunity to communicate with Doctor/staff, request prescription refills, etc.

How to Participate in the Patient Portal:

Once we have processed your info you will be given a login and temporary password. You will have the opportunity to personalize your password once in the portal.

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.

Patient/Responsible/Legal Guardian Acknowledgement:

_____

Signature **Today's date**