The contents of this package are your first step to restore your vitality. Please take time to read this carefully and answer all the questions as completely as possible.

Thank you for your interest in BioTE Medical®. In order to determine if you are a candidate for bio-identical testosterone pellets, we need laboratory and your history forms. We will evaluate your information prior to your consultation to determine if BioTE Medical® can help you live a healthier life. **Please complete the following tasks before your appointment:**

2 weeks or more before your scheduled consultation: Get your blood labs drawn at any Quest Diagnostics or LabCorp. If you are not insured or have a high deductible, call our office for self-pay blood draws. We request the tests listed below. It is your responsibility to find out if your insurance company will cover the cost, and which lab to go to. **Please note that it can take up to two weeks for your lab results to be received by our office.**

Your blood work panel MUST include the following tests:

___Estradiol
___FSH
___Testosterone Total
___TSH
___T4, Total
___T3, Free
___T.P.O. Thyroid Peroxidase
___CBC
___Complete Metabolic Panel
___Vitamin D, 25-Hydroxy (Optional)
___Vitamin B12 (Optional)
___Lipid Panel (Optional) **(Must be a fasting blood draw to be accurate)**

Female Post Insertion Labs Needed at 4, 6 or 8 Weeks based on your practitioner's choice:

___FSH
___Testosterone Total
___CBC
___Lipid Panel (Optional) (**Must be a fasting blood draw to be accurate**)
___TSH, T4 Total, Free T3, TPO (**Needed only if you've been prescribed thyroid medication**
___ Estradiol

Family First WELLNESS

Female Patient Questionnaire & History

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

Date of Birth:_____ Age:_____ Weight:_____ Occupation: _____

Home Address: _____

City: _____ State:_____ Zip:_____ Phone: _____

Social Security #:_____ Driver's License (State/Number/Expiration):_____

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:

- ☐ I am sexually active
- ☐ I want to be sexually active
- ☐ I have completed my family
- ☐ My sex has suffered
- ☐ I haven't been able to have an orgasm.

Habits:

- ☐ I smoke cigarettes or cigars_____ per day
- ☐ I drink alcoholic beverages_____ per week
- ☐ I drink more than 10 alcoholic beverages a week
- ☐ I use caffeine__a day

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Medical History

Any known drug allergies: _____

Have you ever had any issues with anesthesia? ☐ Yes ☐ No If yes, pleaseexplain: _____

Medications Currently Taking: _____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Nutritional/Vitamin Supplements: _____

Surgeries, list all and when: _____

Last menstrual period (estimate year if unknown): _____

Other Pertinent Information: _____

Preventative Medical Care:

- ☐ Medical/GYN exam in the last year
- ☐ Mammogram in the last 12 months
- ☐ Bone density in the last 12 months
- ☐ Pelvic ultrasound in the last 12 months.

High Risk Past Medical/Surgical History:

- ☐ Breast cancer
- ☐ Uterine cancer
- ☐ Ovarian cancer
- ☐ Hysterectomy with removal of ovaries
- ☐ Hysterectomy only
- ☐ Oophorectomy removal of ovaries.

Birth Control Method:

- ☐ Menopause
- ☐ Hysterectomy
- ☐ Tubal ligation
- ☐ Birth control pill
- ☐ Vasectomy
- ☐ Other: _____

Medical Illnesses:

- ☐ Polycystic Ovary Syndrome (PCOS)
- ☐ High blood pressure
- ☐ Heart bypass
- ☐ High cholesterol
- ☐ Hypertension
- ☐ Heart disease
- ☐ Stroke and/or heart attack
- ☐ Blood clot and/or a pulmonary embolus
- ☐ Arrhythmia
- ☐ Any form of Hepatitis or HIV
- ☐ Lupus or other auto immune disease
- ☐ Fibromyalgia
- ☐ Trouble passing urine or take Flomax or Avodart
- ☐ Chronic liver disease (hepatitis, fatty liver, cirrhosis)
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Arthritis
- ☐ Depression/anxiety
- ☐ Psychiatric disorder
- ☐ Cancer (type): _____ Year:_____

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Female Testosterone and/or Estradiol Pellet Insertion Consent Form

Bio-identical hormone pellets are hormones, biologically identical to the hormones you make in your own body prior to menopause. Estrogen and testosterone were made in your ovaries and adrenal gland prior to menopause. Bio-identical hormones have the same effects on your body as your own estrogen and testosterone did when you were younger, without the monthly fluctuations (ups and downs) of menstrual cycles.

Bio-identical hormone pellets are plant derived and are FDA monitored, but not approved for female hormonal replacement. The pellet method of hormone replacement has been used in Europe and Canada for many years and by select OB/GYNs in the United States. You will have similar risks as you had prior to menopause, from the effects of estrogen and androgens, given as pellets.

Patients who are pre-menopausal are advised to continue reliable birth control while participating in pellet hormone replacement therapy. Testosterone is category X (will cause birth defects) and cannot be given to pregnant women.

My birth control method is: (please circle):

Abstinence Birth control pill Hysterectomy IUD Menopause Tubal ligation Other:_____

CONSENT FOR TREATMENT: I consent to the insertion of testosterone and/or estradiol pellets in my hip. I have been informed that I may experience any of the complications to this procedure as described below. These side effects are similar to those related to traditional testosterone and/or estrogen replacement. **Surgical risks are the same as for any minor medical procedure and are included in the list of overall risks below:**

Bleeding, bruising, swelling, infection and pain; reaction to local anesthetic and/or preservatives; extrusion of pellets; hyper sexuality (overactive Libido); lack of effect (from lack of absorption); breast tenderness and swelling especially in the first three weeks (estrogen pellets only); increase in hair growth on the face, similar to pre-menopausal patterns; water retention (estrogen only); increased growth of estrogen dependent tumors (endometrial cancer, breast cancer); birth defects in babies exposed to testosterone during their gestation; growth of liver tumors, if already present; 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, or thicken one's blood. This problem can be diagnosed with a blood test. Thus, a complete blood count (Hemoglobin & Hematocrit) 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 weight; decrease in risk or severity of diabetes; decreased risk of heart disease; decreased risk of Alzheimer's and dementia.

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** _____ **Date** _____

Family First WELLNESS

HEALTH ASSESSMENT FOR WOMEN

SYMPTOM	NEVER	MILD	MODERATE	SEVERE
Depressive Mood				
Memory Loss				
Mental Confusion				
Decreased sex drive/libido				
Sleep problems				
Mood Changes/Irritability				
Migraine/Severe Headaches				
Tension				
Difficult to climax sexually				
Bloating				
Weight Gain				
Breast tenderness				
Vaginal Dryness				
Hot flashes				
Night sweats				
Dry and wrinkled skin				
Hair falling out				
Cold all the time				
Swelling all over the body				
Joint Pain				

FAMILY HISTORY

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

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HIPAA Information & 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. 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

What we have adopted:

- 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.
- 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.
- 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.
- 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.
- You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the provider.
- Your confidential information will be used for the purposes of marketing or advertising of products, goods or services with your consent only.
- We agree to provide patients with access to their records in accordance with state and federal laws. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
- 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** **Date**

Family First WELLNESS

POST-INSERTION INSTRUCTIONS FOR WOMEN

- Your insertion site has been covered with two layers of bandages. Remove the outer pressure bandage anytime after 24 hours. It must be removed as soon as it gets wet. The inner layer is either waterproof foam tape or steri-strips. They should be removed in 3 days.
- We recommend putting an ice pack on the insertion area a couple of times for about 20 minutes each time over the next 4-5 hours.
- DO NOT take tub baths or get into a hot tub or swimming pool for 3 days. You may shower but do not scrub the site until the incision is well healed (about 7 days).
- No major exercises for the incision area for the next 3 days, this includes running, elliptical, squats, lunges, etc.
- The sodium, bicarbonate in the anesthetic may cause the site to swell for 1-3 days/
- The insertion site may be uncomfortable for up to 2-3 weeks. If there is itching or redness you may take Benadryl for relief, 50 mg orally every 6 hours. Caution this can cause drowsiness!
- You may experience bruising, swelling, and/or redness of the insertion site which may last from a few days to up to 2-3 weeks.
- You may notice some pinkish or bloody discoloration of the outer bandage. This is normal.
- If you experience bleeding from the incision, apply firm pressure for 5 minutes.
- Please call if you have any bleeding not relieved with pressure (not oozing) as this is NOT normal.
- Please call if you have any puss coming out of the insertion site as this is NOT normal.

REMINDERS!

- Remember to go for your post-insertion blood work 6 weeks after the insertion.
- Most women will need re-insertions of their pellets 3-4 months after their initial insertion.
- Please call as soon as symptoms that were relieved from the pellets start to return to make an appointment for a re-insertion. The charge for the 2nd and subsequent visits will only be for the insertion.

ADDITIONAL INSTRUCTIONS: _____

_____

_____

_____ _____

Print Name **Signature** **Date**

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Family First Wellness 2101 S. Loop 336 W, Conroe, TX 77304 Tel. 936.235.2825 ❖ Fax 936.235.2826

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. If you would like, we are happy to provide any paperwork you may need to file with your insurance for reimbursement.

New Patient Consult Fee	**$75.00**
Female Hormone Pellet Insertion Fee	**$350.00**
Male Hormone Pellet Insertion Fee	**$650.00**
Male Pellet Insertion Fee (≥2000mg)	**$750.00**

We accept the following forms of payment:

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

Print Name **Signature** **Date**