

## Hormone Replacement Fee Acknowledgment

Preventative medicine and bio-identical 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 and RN's or NP's, insurance does not recognize it as necessary and therefore is not covered by health insurance in most cases.

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

The form and receipt are your responsibility and serve as evidence of your treatment. We will not call, write, pre-certify, or make any contact with your insurance company. Any follow up letters from your insurance to us will be thrown away. If we receive a check from your insurance company, we will not cash it, but instead 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.

**New Patient Consult Fee** ..... ~~\$70.00~~ <sup>60.00</sup>

(Includes comprehensive lab review, applied to the cost of pelleting if you choose to proceed with treatment.)

**Female Hormone Pellet Treatment**..... ~~\$550.00~~

(Includes comprehensive lab review, pellets, procedure fee, follow-up care & any necessary pellet boosts.)

**Pre & Post Hormone Follow up visits** ..... ~~\$70.00~~ <sup>60.00</sup>

(This represents follow up appointments 4 weeks post pellet insertion and prior to next implementation. Includes follow up lab reviews.)

### We accept the following forms of payment:

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

---

Print Name

Signature

Today's Date

## Female Testosterone and/or Estradiol Pellet Insertion Consent Form

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
(Last) (First) (Middle)

Bio-identical hormone pellets are concentrated 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 made from yam 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 cannot 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. 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.**

**Side effects may include:** Bleeding, bruising, swelling, infection and pain; 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); safety of any of these hormones during pregnancy cannot be guaranteed. Notify your provider if you are pregnant, suspect that you are pregnant or are planning to become pregnant during this therapy, continuous exposure to testosterone during pregnancy may cause genital ambiguity; 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 and 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 agree to immediately report to my practitioner's office any adverse reaction or problems that might 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 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. 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

## BHRT CHECKLIST FOR WOMEN

Name: \_\_\_\_\_

Date: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Symptom <i>(please check mark)</i>	Never	Mild	Moderate
Depressive mood			
Memory Loss			
Mental confusion			
Decreased sex drive/libido			
Sleep problems			
Mood changes/Irritability			
Tension			
Migraine/severe headaches			
Difficult to climax sexually			
Bloating			
Weight gain			
Breast tenderness			
Vaginal dryness			
Hot flashes			
Night sweats			
Dry and Wrinkled Skin			
Hair is Falling Out			
Cold all the time			
Swelling all over the body			
Joint pain			

Other symptoms that concern you:


## Medical History

Any known drug 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 period (estimate year if unknown): \_\_\_\_\_

Other Pertinent Information: \_\_\_\_\_

---

---

---

## Female Patient Questionnaire & History

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
(Last) (First) (Middle)

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

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 means 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: \_\_\_\_\_

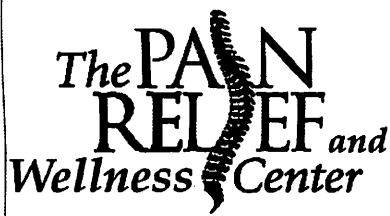
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work: \_\_\_\_\_

### 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.



## Female New Patient Package

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.

We look forward to partnering with you to help you feel your best again.

Thank you for your interest in bio-identical hormone pellet therapy. In order to determine if you are a candidate for pellet therapy, we need laboratory and your history forms. We will evaluate your information prior to your consultation to determine if pellet therapy 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 FASTING blood lab drawn at any Quest Laboratory or LabCorp Lab. 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. Please fast for 12 hours prior to your blood draw.**

### Your fasting 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)