

## Female Patient History and Questionnaire

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: \_\_\_\_\_

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 you are giving us permission to speak with your spouse or significant other about your treatment. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

How did you hear about our practice? \_\_\_\_\_

### Social:

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

### Habits:

- ( ) I smoke cigarettes \_\_\_\_\_ per day.
- ( ) I drink alcoholic beverages \_\_\_\_\_ per week.
- ( ) I use caffeine \_\_\_\_\_ a day.



Hormonal Vitality & Wellness Center

### 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: \_\_\_\_\_

#### 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 Pills.
- ( ) Vasectomy.
- ( ) Other: \_\_\_\_\_

#### Medical Illnesses:

- ( ) High blood pressure.
- ( ) Heart bypass.
- ( ) High cholesterol.
- ( ) Hypertension.
- ( ) Heart Disease.
- ( ) Stroke and/or heart attack.
- ( ) Blood clot and/or a pulmonary emboli.
- ( ) 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: \_\_\_\_\_

# Restore

Hormonal Vitality & Wellness Center

You have supplied information that may relate to hormonal imbalance producing symptoms that are expressed physically or emotionally. Here at Restore Hormonal Vitality and Wellness Center, we are mindful that total restoration or true health also includes the health of our spirit. If you as well are attuned to the spirit's effect on true health, we encourage you to consider answering the following:

	YES	NO
Spiritual health is important to me	_____	_____
I am connected to a community of faith	_____	_____
I have a concern that a spiritual issue is currently affecting my true health	_____	_____
I would like to discuss my spiritual health	_____	_____

## BHRT Checklist For Women

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

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

Symptom (please check mark)	Never	Mild	Moderate	Severe
Depressive mood				
Fatigue				
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				

### Family History

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



## 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 \_\_\_\_\_



## 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.

<b>New Patient Consult Fee</b>	<b>\$250</b>
<b>Female Hormone Pellet Insertion Fee</b>	<b>\$395</b>
<b>Male Hormone Pellet Insertion Fee</b>	<b>\$795</b>

**We accept the following forms of payment:**

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

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Print Name

Signature

Today's Date



## INSURANCE DISCLAIMER

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 medicine BUT is considered like plastic surgery (esthetic medicine) and therefore is not covered by health insurance in most cases.

Restore Hormonal Vitality & Wellness Center 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.

For patients who have access to Health Savings Account, you may pay for your treatment with that credit or debit card. This is the best idea for those patients who have an HSA as an option in their medical coverage.

Name: \_\_\_\_\_ 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](http://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, \_\_\_\_\_date\_\_\_\_\_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.

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