Ageless Expressions MedSpa

Male 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.

Thank you for your interest in Ageless Expressions MedSpa, a BioTE Medical®Provider. 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:**

One week or more before your scheduled consultation: Get your blood lab drawn at any Quest Laboratory/ or LabCorp Lab using the lab order form we provide. **IF YOU ARE NOT INSURED OR HAVE A HIGH DEDUCTIBLE, CALL OUR OFFICE FOR SELF-PAY LAB OPTIONS.** 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 one week for your lab results to be received by our office. Please fast for 12 hours prior to your blood draw.**

Your blood work panel should include the following tests:

___ Estradiol
___ Testosterone Free & Total
___ PSA Total
___ TSH
___ T4, Total
___ T3, Free
___ T.P.O. Thyroid Peroxidase
___ CBC
___ Complete Metabolic Panel
___ Vitamin D, 25-Hydroxy
___ Lipid Panel (Optional) **(Must be a fasting blood draw to be accurate)**

Male Post Insertion Labs Needed at 4 Weeks:

___ Estradiol
___ Testosterone Free & Total
___ PSA Total (If PSA was borderline on first insertion)
___ CBC
___ Lipid Panel (Optional) **(Must be a fasting blood draw to be accurate)**
___ TSH, T4 Total, T3 Free, TPO (**Only needed if you've been prescribed thyroid medication**)

Male Patient Questionnaire & History

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

Date of Birth:_____Age:_____Weight:_____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: _____

Referral Source _____
Name/Place

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.
( ) I have used steroids in the past for athletic purposes.

Habits:

( ) I smoke cigarettes or cigars _____ a day.
( ) I drink alcoholic beverages _____ per week.
( ) I drink more than 10 alcoholic beverages a week.
( ) I use caffeine _____ a day.
( ) I use recreational drugs Type _____ Frequency _____

Medical History

Patient Name: _____ Date:_____

Age: _____ DOB:_____ Height: _____ Weight: _____

List any known allergies and reactions: _____

When was the last time you saw a doctor for a physical exam? _____

What area(s) of improvement are you interested in: _____

Current/past hormone replacement therapy: _____

List any ED medications you are currently taking or have used in the past: _____

Did they work?: _____

List all medications and/or supplements you are currently taking:

Name	Dose	Frequency	Reason

Medical Illnesses:

( ) 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
( ) Elevated PSA
( ) Prostate enlargement
( ) Trouble passing urine or take Flomax or Avodart
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis)
( ) Diabetes
( ) Thyroid disease
( ) Arthritis
( ) STDs (type) _____

History of surgeries/trauma: _____

Other pertinent information your provider should know? _____

_____

Current or previous use of nitrates (for chest pain)? Yes No

I certify that the above information is correct to the best of my knowledge. I will not hold my practitioner or any members of the staff responsible for any errors or omission that I may have made in the completion of this form.

Signature:_____ Date:_____

BHRT CHECKLIST FOR MEN

Name: _____ **Date:** _____

E-Mail: _____

Symptom *(please check mark)*	**Never**	**Mild**	**Moderate**	**Severe**
Decline in general well being				
Joint pain/muscle ache				
Excessive sweating				
Sleep problems				
Increased need for sleep				
Irritability				
Nervousness				
Anxiety				
Depressed mood				
Exhaustion/lacking vitality				
Declining Mental Ability/Focus/Concentration				
Feeling you have passed your peak				
Feeling burned out/hit rock bottom				
Decreased muscle strength				
Weight Gain/Belly Fat/Inability to Lose Weight				
Breast Development				
Shrinking Testicles				
Rapid Hair Loss				
Decrease in beard growth				
New Migraine Headaches				
Decreased desire/libido				
Decreased morning erections				
Decreased ability to perform sexually				
Infrequent or Absent Ejaculations				
No Results from E.D. Medications				

Family History

	NO	**YES**
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		

Ageless Expressions MedSpa

Patient Name:_____Patient DOB:_____

Email:_____Phone Number: _____

Procedure: **GAINSWave** **Priapus Shot** **GAINSWave + Priapus Shot**

Primary Goal**: Erectile Performance ED Peyronie's**

Medical History**: DM HTN CVD**

Current Med Use**: Beta-Blockers SSRIs PDE5i [Cialis, Viagra]**

Prior use of PDE5i: **(circle one) YES NO** PDE5i Response**: None / Poor / Good**

Currently Using/Previous Use of Nitrates: **(circle one) YES NO**

The Erectile Hardness Score [*choose one*]

1. Penis is larger but not hard
2. Penis is hard, but not hard enough for penetration
3. Penis is hard enough for penetration, but not completely hard
4. Penis is completely hard and fully rigid

SHIM

1. How would you rate your confidence that you can get and keep an erection? _____
1=very low 2=low 3=moderate 4=high 5=very high

2. When you have erections with sexual stimulation how often were your erections hard enough for penetration? _____
1=never 2= a few times 3=sometimes 4=most times 5=always

3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated your partner? _____
1=never 2=a few times 3=sometimes 4=most times 5=always

4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse? _____
1=extremely difficult 2=very difficult 3=difficult 4=slightly difficult 5=not difficult

5. When you attempted sexual intercourse, how often was it satisfactory for you? _____
1=never 2=a few times 3=sometimes 4=most times 5=always

For office use only:

RESULTS

Follow up: DATE:___/___/____

Erectile Hardness Score _____

SHIM Total Score_____
1-7 Severe ED 8-11Moderate ED 12-16 Mild moderate ED 17-21Mild ED 22-25No ED

Fax completed form back to Attn: Medical Department: _____

Testosterone Pellet Insertion Consent Form

Bio-identical testosterone pellets are hormone, biologically identical to the testosterone that is made in your own body. Testosterone was made in your testicles prior to "andropause." Bio-identical hormones have the same effects on your body as your own testosterone did when you were younger. Bio-identical hormone pellets are plant derived and bio-identical hormone replacement using pellets has been used in Europe, the U.S. and Canada since the 1930's. Your risks are similar to those of any testosterone replacement but may be lower risk than alternative forms. During andropause, the risk of not receiving adequate hormone therapy can outweigh the risks of replacing testosterone.

Potential risks of not receiving testosterone therapy after andropause include but are not limited to: Arteriosclerosis, elevation of cholesterol, obesity, loss of strength and stamina, generalized aging, osteoporosis, mood disorders, depression, arthritis, loss of libido, erectile dysfunction, loss of skin tone, diabetes, increased overall inflammatory processes, dementia and Alzheimer's disease, and many other symptoms of aging.

Alternatives: Alternative treatment options are available to include gels and injections. We do not provide these options through our practice. You also have the option of declining our services and consulting other providers.

CONSENT FOR TREATMENT: I consent to the insertion of testosterone pellets in my hip. I have been informed that I may experience any of the complications to this procedure as described below. **Surgical risks are the same as for any minor medical procedure.**

Side effects may include: Bleeding, bruising, swelling, infection, pain, reaction to local anesthetic and/or preservatives, lack of effect (typically from lack of absorption), thinning hair, male pattern baldness, increased growth of prostate and prostate tumors, extrusion of pellets, hyper sexuality (overactive libido), ten to fifteen percent shrinkage in testicle size and significant reduction in sperm production.

There is some risk, even with natural testosterone therapy, of enhancing an existing current prostate cancer to grow more rapidly. For this reason, a prostate specific antigen blood test is to be done before starting testosterone pellet therapy and will be conducted each year thereafter. If there is any question about possible prostate cancer, a follow-up with an ultrasound of the prostate gland may be required as well as a referral to a qualified specialist. While urinary symptoms typically improve with testosterone, rarely they may worsen, or worsen before improving. 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.

RESEARCH INDICATEDS THE BENEFITS OF TESTOSTERONE PELLETS MAY INCLUDE: Individuals respond to care differently, what we typically see is improvement of your overall wellbeing and a decrease in your symptoms. Most patients have reported the following: 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 (secondary to hormonal decline); decreased weight (increase in lean body mass); Studies indicate a decrease in risk or severity of diabetes; decreased risk of Alzheimer's and dementia; and decreased risk of heart disease in men less than 75 years old with no pre-existing history of heart disease.

On January 31, 2014, the FDA issued a Drug Safety Communication indicating that the FDA is investigating risk of heart attack and death in some men taking FDA approved testosterone products. The risks were found in men over the age of 65 years old with pre-existing heart disease and men over the age of 75 years old with or without pre-existing heart disease. These studies were performed with testosterone patches, testosterone creams and synthetic testosterone injections and did not include subcutaneous hormone pellet therapy.

I agree to immediately report to my practitioner's office any adverse reactions or problems that may 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. I agree that I may be seen by a physician, RN, or NP who will act within the legal guidelines of their practice. I understand that only an appropriately licensed prescribing provider may order medications and has authority to modify the dose or frequency of the medications ordered. I may request to consult with the physician at any time. Furthermore, I have not been promised or guaranteed any specific benefits from the administration of bio-identical therapy. I certify this form has been fully explained to me, and I have read it or have had it read to me and I understand its contents. 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.

New Patient Consult Fee	**$125.00**
Female Hormone Pellet Insertion Fee	**$325.00**
Male Hormone Pellet Insertion Fee	**$625.00**
Male Hormone Pellet Insertion Fee (>2000mg)	**$725.00**

We accept the following forms of payment:

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

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