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 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 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 blood work panel MUST 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**)

Place Your Logo Here

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: _____

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.
( ) 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.

Place Your
Logo Here

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: _____

Other Pertinent Information: _____

_____

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.

I understand that if I begin testosterone replacement with any testosterone treatment, including testosterone pellets, that I will produce less testosterone from my testicles and if I stop replacement, I may experience a temporary decrease in my testosterone production. Testosterone Pellets should be completely out of your system in 12 months.

By beginning treatment, I accept all the risks of therapy stated herein and future risks that might be reported. I understand that higher than normal physiologic levels may be reached to create the necessary hormonal balance.

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

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.

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.

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.

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 (secondary to hormonal decline); decreased weight (increase in lean body mass); 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. 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

Prostate Cancer Waiver for Testosterone Pellet Therapy

I, (patient name)_____, voluntarily choose to undergo implantation of subcutaneous bio-identical testosterone pellet therapy with, (Treating Provider) ___ even though I have a history of prostate cancer. I understand that such therapy is controversial and that many doctors believe that testosterone replacement in my case is contraindicated. My Treating Provider has informed me it is possible that taking testosterone could possibly cause cancer, or stimulate existing prostate cancer (including one that has not yet been detected). Accordingly, I am aware that prostate cancer or other cancer could develop while on pellet therapy.

I have assessed this risk on a personal basis, and my perceived value of the hormone therapy outweighs the risk in my mind. I am, therefore, choosing to undergo the pellet therapy despite the potential risk that I was informed of by my Treating Provider.

I acknowledge that I bear full responsibility for any personal injury or illness, accident, risk or loss (including death and/or prostate issues) that may be sustained by me in connection with my decision to undergo testosterone pellet therapy including, without limitation, any cancer that should develop in the future, whether it be deemed a stimulation of a current cancer or a new cancer. I hereby release and agree to hold harmless Dr. Donovitz, Treating Provider, BioTE® Medical, LLC., and any of their BioTE® Medical physicians, nurses, officers, directors, employees and agents from any and all liability, claims, demands and actions arising or related to any loss, property damage, illness, injury or accident that may be sustained by me as a result of testosterone pellet therapy. I acknowledge and agree that I have been given adequate opportunity to review this document and to ask questions. This release and hold harmless agreement is and shall be binding on myself and my heirs, assigns and personal representatives

_____ _____

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

Prostate Exam Waiver for Testosterone Pellet Therapy

I, (patient name)_____, voluntarily choose to undergo implantation of subcutaneous bio-identical testosterone pellet therapy with, (Treating Provider)_____.

For today's appointment, I have not provided you with a prostate exam report, due to the following reason:

( ) My decision not to have a prostate exam.

( ) I am unable to provide it at this time.

I am aware that a current report must be sent by mail or faxed to our office prior to my next HRT appointment. The Treating Provider has discussed the importance and necessity of prostate exam since I receive testosterone.

(Initials of patient)_____

A prostate exam is the best single method for detection of early prostate cancer. I understand that my refusal to submit to a prostate exam may result in cancer remaining undetected within my body. Hormone therapy may increase the risk of increase of such undetected cancer.

I acknowledge that I bear full responsibility for any personal injury or illness, accident, risk or loss (including death and/or prostate issues) that may be sustained by me in connection with my decision to undergo testosterone pellet therapy including, without limitation, any cancer that should develop in the future, whether it be deemed a stimulation of a current cancer or a new cancer. I hereby release and agree to hold harmless Dr. Donovitz, Treating Provider, BioTE® Medical, LLC., and any of their BioTE® Medical physicians, nurses, officers, directors, employees and agents from any and all liability, claims, demands and actions arising or related to any loss, property damage, illness, injury or accident that may be sustained by me as a result of testosterone pellet therapy. I acknowledge and agree that I have been given adequate opportunity to review this document and to ask questions. This release and hold harmless agreement is and shall be binding on myself and my heirs, assigns and personal representatives

Patient 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, _____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.

_____