139 Executive Circle, Daytona Beach, Florida, 32114; Phone: (386) 232-5505

Name: _____ Date of birth: _____

MALE NEW PATIENT PACKAGE

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

Thank you for your interest in hormone optimization. In order to determine if you are a candidate for bioidentical hormone replacement, we need laboratory information and your medical history forms. We will evaluate your information prior to your consultation to determine if the Biote Method® of hormone replacement 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 blood lab drawn at the lab of your choice. If you have had labs drawn at another office in the last year, please get a copy of those results to us BEFORE your labs are drawn as insurance may not cover duplicate lab tests. 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 use.**

Your blood work panel MUST include the following tests

- Estradiol _____
- Testosterone, free & total _____
- PSA, total (ages 55-69 or high-risk) _____
- T3, free _____
- T4, total _____
- TSH _____
- TPO or thyroid peroxidase _____
- CBC _____
- Complete metabolic panel _____
- Vitamin D, 25-hydroxy _____
- Vitamin B12 _____
- Lipid panel (optional) _____
- Homocysteine (optional) _____
- A1C (optional) _____
- Reverse T3 (optional) _____
- Anti-thyroglobulin antibody (optional) _____

Male post insertion labs needed at 4 weeks:

- Estradiol _____
- Testosterone, free & total _____
- PSA, total (If PSA was borderline on first insertion) _____
- CBC _____
- Free T3, free T4, TSH (only if on new prescription or change in thyroid medication) _____
- Other _____

Miscellaneous other labs (possibly needed)

- Prolactin (age < 40 OR T < 300) _____
- Sleep study (snoring or T < 300) _____
- Semen analysis _____
- Other _____

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MALE HEALTH ASSESSMENT

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark "none".

Symptoms	None (0)	Mild (1)	Moderate (2)	Severe (3)	Very severe (4)
Sweating (night sweats or excessive sweating)	☐	☐	☐	☐	☐
Sleep problems (difficulty falling asleep, sleeping through the night or waking up too early)	☐	☐	☐	☐	☐
Increased need for sleep or falls asleep easily after a meal	☐	☐	☐	☐	☐
Depressive mood (feeling down, sad, lack of drive)	☐	☐	☐	☐	☐
Irritability (mood swings, feeling aggressive, angers easily)	☐	☐	☐	☐	☐
Anxiety (inner restlessness, feeling panicked, feeling nervous, inner tension)	☐	☐	☐	☐	☐
Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation)	☐	☐	☐	☐	☐
Sexual problems (change in sexual desire or in sexual performance)	☐	☐	☐	☐	☐
Bladder problems (difficulty in urinating, increased need to urinate)	☐	☐	☐	☐	☐
Erectile changes (weaker erections, loss of morning erections)	☐	☐	☐	☐	☐
Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)	☐	☐	☐	☐	☐
Difficulties with memory	☐	☐	☐	☐	☐
Problems with thinking, concentrating or reasoning	☐	☐	☐	☐	☐
Difficulty learning new things	☐	☐	☐	☐	☐
Trouble thinking of the right word to describe persons, places or things when speaking	☐	☐	☐	☐	☐
Increase in frequency or intensity of headaches/migraines	☐	☐	☐	☐	☐
Rapid hair loss or thinning	☐	☐	☐	☐	☐
Feel cold all the time or have cold hands or feet	☐	☐	☐	☐	☐
Weight gain, increased belly fat, or difficulty losing weight despite diet and exercise	☐	☐	☐	☐	☐
Infrequent or absent ejaculations	☐	☐	☐	☐	☐
Total score	0				

Severity score: Mild: 1-20 / Moderate: 21-40 / Severe: 41-60 / Very severe: 61-80

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HORMONE REPLACEMENT FEE ACKNOWLEDGMENT & INSURANCE DISCLAIMER

Preventative medicine and bioidentical 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, nurses, nurse practitioners and/or physician assistants, insurance does not recognize bioidentical hormone replacement as necessary medicine BUT rather more like plastic surgery (aesthetic medicine). Therefore, bioidentical hormone replacement is not covered by health insurance in most cases.

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

This form and your receipt are your responsibility and serve as evidence of your treatment. We will not call, write, pre-certify, appeal nor make any contact with your insurance company. If we receive a check from your insurance company, we will not cash it but will 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. Some of these accounts require that you pay in full ahead of time, however, and request reimbursement later with a receipt and letter. This is the best idea for those patients who have an HSA as an option in their medical coverage. It is your responsibility to request the receipt and paperwork to submit for reimbursement.

New patient office visit fee ..... $.....

Male hormone pellet insertion fee ..... $.....

We accept the following forms of payment:

.....

Print name: _____

Signature: _____ Date: _____

139 Executive Circle, Daytona Beach, Florida, 32114; Phone: (386) 232-5505

Name: _____ Date of birth: _____

Date: _____ Diagnosis: ICD10 _____

Re: Reimbursement for services

MALE LETTER OF NECESSITY FOR PELLET THERAPY

To whom it may concern:

_____

_____

Pellets are derived from natural plant-based ingredients. They are formulated in specialized 503B compounding pharmacies and possess the exact hormonal structure of the human hormone testosterone. These pellets, once implanted, secrete hormones in tiny amounts into the bloodstream constantly. No other form of testosterone delivery, whether injections, gels, sprays, creams, or patches can produce the consistent blood level of testosterone that pellets can. Pellet therapy is the only method of testosterone therapy that gives sustained and consistent testosterone levels throughout the day, for 4 to 6 months, without a "roller coaster" effect. Other forms of testosterone therapy simply cannot deliver such steady hormone levels.

The dosages are individualized by the physician or practitioner for the patient taking into consideration his current and past medical history as well as prior experience with other forms of therapy, current medications, etc. No other form of therapy has unique dosages which can be tailored to each individual patient to suit his special needs.

The above patient was seen in my office and was diagnosed with:

☐ Testosterone deficiency syndrome

His lab values and symptoms are consistent with this diagnosis. Prior to pellet therapy, the patient experienced symptoms such as:

☐ Decreased libido ☐ Decreased energy ☐ Mood swings ☐ Anxiety ☐ Poor memory

☐ Lack of mental clarity ☐ Joint pain ☐ Lethargy and/or ☐ Other _____

Pellet therapy helps alleviate these symptoms and helps improve his quality of life both physically and mentally and has benefited his overall well-being. Please honor his request for reimbursement.

Sincerely,

_____

Doctor or clinic name

139 Executive Circle, Daytona Beach, Florida, 32114; Phone: (386) 232-5505

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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 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.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM.

Print name: _____

Signature: _____ Date: _____

139 Executive Circle, Daytona Beach, Florida, 32114; Phone: (386) 232-5505

Name: _____ Date of birth: _____

MALE PATIENT QUESTIONNAIRE & HISTORY

Name: _____ Date: _____

Date of birth: _____ Age: _____ Weight: _____ Occupation: _____

Home address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Work: _____

Preferred contact number: _____

May we send messages via text regarding appts to your cell? ☐ Yes ☐ No

Email address: _____ May we contact you via email? ☐ 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 have 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.

Name: _____ Relationship: _____

Home phone: _____ Cell phone: _____ Work: _____

Social:

☐ I am sexually active.	OR	☐ I want to be sexually active.	☐ I do not want to be sexually active.
☐ I have completed my family.	OR	☐ I have NOT completed my family.	
☐ My sex life has suffered.	OR	☐ I have not been able to have an orgasm or it is very difficult.	

Habits:

☐ I smoke cigarettes or cigars ____ per day. ☐ I use e-cigarettes ____ a day. ☐ I use caffeine ____ a day.

☐ I drink alcoholic beverages ____ per week. ☐ I drink more than 10 alcoholic beverages a week.

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MALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

Drug allergies

Drug allergies: _____ If yes, please explain: _____

Have you ever had any issues with local anesthesia? ☐ Yes ☐ No Do you have a latex allergy? ☐ Yes ☐ No

Medications currently taking: _____

Current hormone replacement? ☐ Yes ☐ No If yes, what? _____

Past hormone replacement therapy: _____

Family history:

☐ Heart disease ☐ Diabetes ☐ Osteoporosis ☐ Alzheimer's/dementia ☐ Breast cancer ☐ Other_____

Pertinent medical/surgical history:

☐ Cancer (type):
Year: _____
☐ Elevated PSA
☐ Trouble passing urine
☐ Taking medicine for prostate or male-pattern balding
☐ History of anemia
☐ Vasectomy
☐ Erectile dysfunction
☐ Testicular or prostate cancer
☐ Prostate enlargement or BPH
☐ Kidney disease or decreased kidney function
☐ Frequent blood donations
☐ Non-cancerous testicular or prostate surgery
☐ Severe snoring
☐ Taking medicine for high cholesterol

Birth Control Method:

☐ Not applicable
☐ None - planning pregnancy in the next year
☐ Depend on partner's contraception
☐ Vasectomy
☐ Condoms
☐ Other: _____

Activity Level:

☐ Low – sedentary
☐ Moderate – walk/jog/workout infrequently
☐ Average – walk/jog/workout 1 to 3 times per week
☐ High – walk/jog/workout regularly 4+ times per week

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MALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

Medical history:

- ☐ High blood pressure or hypertension
- ☐ Heart disease
- ☐ Atrial fibrillation or other arrhythmia
- ☐ Blood clot and/or a pulmonary embolism
- ☐ Depression/anxiety
- ☐ Chronic liver disease (hepatitis, fatty liver, cirrhosis)
- ☐ Arthritis
- ☐ Hair thinning
- ☐ Sleep apnea
- ☐ High cholesterol
- ☐ Stroke and/or heart attack
- ☐ HIV or any type of hepatitis
- ☐ Hemochromatosis
- ☐ Psychiatric disorder
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Lupus or other autoimmune disease
- ☐ Other _____