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.

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.

Get your blood labs drawn at any DRL, Quest Diagnostics 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.**

Your blood work panel MUST include the following tests:

- Estradiol
- FSH
- Testosterone Total, Free, and SHBG
- TSH
- T4, Total
- T3, Free
- T.P.O. Thyroid Peroxidase
- CBC
- Complete Metabolic Panel
- Vitamin D
- Prolactin

Female Post Insertion Labs Needed at 4, 6 or 8 Weeks based on your practitioner's choice:

- FSH
- Testosterone Total, Free, and SHBG
- CBC
- Estradiol
- TSH, T4 Total, Free T3, TPO (**Needed only if you've been prescribed thyroid medication)**

Female Patient Questionnaire & History

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

Date of Birth: _____/_____/_____Age: _____ Weight: _____ Height: _____

Home Address: _____

City:_____State:_____Zip: _____

Home Phone: _____Cell Phone:_____Work: _____

Circle Cell Phone Provider: Verizon / AT&T / T-Mobile / Sprint / Cricket / Other: _____

E-Mail Address:_____ May we contact you via E-Mail? ( ) **YES** ( ) **NO**

In Case of Emergency Contact:_____Relationship: _____

Home Phone: _____ Cell Phone: _____Work_____

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.
( ) My sex has suffered.
( ) I haven't been able to have an orgasm.

Activity Level:

( ) Sedentary
( ) Moderate
( ) Athletic

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.

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:

( ) Polycystic Ovary Syndrome (PCOS)
( ) 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.
( ) Seizures.
( ) Thyroid disease.
( ) Arthritis.
( ) Depression/anxiety.
( ) Psychiatric disorder.
( ) Cancer (type): _____

Year: _____

Health Assessment for Women

Name: _____ **Date:** _____

Symptom (please check mark)	Never	Mild	Moderate	Severe
Depressive mood				
Memory Loss				
Mental confusion				
Decreased sex drive/libido				
Sleep problems				
Mood changes/Irritability				
Fatigue				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and wrinkled skin				
Hair 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 Form

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

Bio-identical hormone pellets are 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 plant derived 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 is category X (will cause birth defects) and 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 and are included in the list of overall risks below:**

Bleeding, bruising, swelling, infection and pain; reaction to local anesthetic and/or preservatives; 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); birth defects in babies exposed to testosterone during their gestation; growth of liver tumors, if already present; 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 & 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 have read and understand the above. I have been encouraged and have had the opportunity to ask any questions regarding pellet therapy. All of my questions have been answered to my satisfaction. I further acknowledge that there may be risks of testosterone and or estrogen therapy that we do not yet know, at this time, and that the risks and benefits of this treatment have been explained to me and I have been informed that I may experience complications, including one or more of those listed above. 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 pellet 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**
Female Hormone Pellet Insertion Fee	**$325**
Male Hormone Pellet Insertion Fee	**$625**
Male Pellet Insertion Fee (≥2000mg)	**$725**

We accept the following forms of payment:

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

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

Post-Insertion Instructions for Women

- Your insertion site has been covered with two layers of bandages. Remove the outer pressure bandage any time after 24 hours. It **must** be removed as soon as it gets wet. The inner layer is either waterproof foam tape or steri-strips. They should be removed in **3 days**.
- We recommend putting an ice pack on the insertion area a couple of times for about 20 minutes each time over the next 4 to 5 hours.
- Do not take tub baths or get into a hot tub or swimming pool for **3 days**. You may shower but do not scrub the site until the incision is well healed (about 7 days).
- No major exercises for the incision area for the next **3 days**, this includes running, bicycling, elliptical, squats, lunges, etc.
- The sodium bicarbonate in the anesthetic may cause the site to swell for 1-3 days.
- The insertion site may be uncomfortable for up to 2 to 3 weeks. If there is itching or redness you may take Benadryl for relief, 50 mg. orally every 6 hours. Caution this can cause drowsiness!
- You may experience bruising, swelling, and/or redness of the insertion site which may last from a few days up to 2 to 3 weeks.
- You may notice some pinkish or bloody discoloration of the outer bandage. This is normal.
- If you experience bleeding from the incision, apply firm pressure for 5 minutes.
- Please call if you have any bleeding not relieved with pressure (not oozing), as this is NOT normal. • Please call if you have any pus coming out of the insertion site, as this is NOT normal.

Reminders:

- Most women will need re-insertions of their pellets **4 months** after their initial insertion.
- Please call as soon as symptoms that were relieved from the pellets start to return to make an appointment for a re-insertion. The charge for the second visit will only be for the insertion and not a consultation.

( ) Post-insertion blood work **6 weeks** after the insertion date is due: _____

( ) Mammogram is due: _____ ( ) Pap Smear is due: _____

( ) DIM 150mg Daily ( ) Spironolactone 50mg Daily

( ) Progesterone 150mg or 200mg every evening. (please do not skip doses of this medication as it can result in vaginal bleeding or an increased risk for endometrial cancer.)

( ) Vitamin D3 10000 IU Daily for 3 months ( ) Vitamin D3 5000 IU Daily ( ) Vitamin ADK

( ) Probiotic Daily ( ) Iodine 12.5 mg _____ ( ) Thyroid Med every AM 30 min before food

If you have any concerns or problems after hours please notify Dr. Stewart at cell number 903-570-3274 or Megan Augustus, NP-C at 903-253-3428

I acknowledge that I have received a copy and understand the instructions on this form.

_____ _____ _____

Print Name Signature Today's Date

WHAT MIGHT OCCUR AFTER A PELLET INSERTION

A significant hormonal transition will occur in the first four weeks after the insertion of your hormone pellets. Therefore, certain changes might develop that can be bothersome.

- **FLUID RETENTION**: Testosterone stimulates the muscle to grow and retain water, which may result in a weight change of two to five pounds. This is only temporary. This happens frequently with the first insertion, and especially during hot, humid weather conditions.

- **SWELLING OF THE HANDS & FEET**: This is common in hot and humid weather. It may be treated by drinking lots of water, reducing your salt intake, taking cider vinegar capsules daily, (found at most health and food stores) or by taking a mild diuretic, which the office can prescribe.

- **UTERINE SPOTTING/BLEEDING**: This may occur in the first few months after an insertion, especially if you have been prescribed progesterone and are not taking properly: i.e. missing doses, or not taking a high enough dose. Please notify the office if this occurs. Bleeding is not necessarily an indication of a significant uterine problem. More than likely, the uterus may be releasing tissue that needs to be eliminated. This tissue may have already been present in your uterus prior to getting pellets and is being released in response to the increase in hormones.

- **MOOD SWINGS/IRRITABILITY**: These may occur if you were quite deficient in hormones. They will disappear when enough hormones are in your system. 5HTP can be helpful for this temporary symptom and can be purchased at many health food stores.

- **FACIAL BREAKOUT**: Some pimples may arise if the body is very deficient in testosterone. This lasts a short period of time and can be handled with a good face cleansing routine, astringents and toner. If these solutions do not help, please call the office for suggestions and possibly prescriptions.

- **HAIR LOSS**: Is rare and usually occurs in patients who convert testosterone to DHT. Dosage adjustment generally reduces or eliminates the problem. Prescription medications may be necessary in rare cases.

- **HAIR GROWTH**: Testosterone may stimulate some growth of hair on your chin, chest, nipples and/or lower abdomen. This tends to be hereditary. You may also have to shave your legs and arms more often. Dosage adjustment generally reduces or eliminates the problem.

- **Breast**: May experience breast/nipple tenderness or sensitivity.

I acknowledge that I have received a copy and understand the instructions on this form.

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

Patient Consent for Use of Email Communications Letter

To better serve our patients, this office has established an email address for some forms of communication. For routine matters that do not require immediate response, please feel free to contact us at info@pureradiancemedspa.com. Please remember however, that this form of communication is not appropriate for use in an emergency. The turnaround time for routine patient communications is the close of each business day (closed on Sunday). If the email is received after the office has already closed, it will be responded to by the end of the next day. The service provider may delay message delivery. Should you require urgent or immediate attention, this medium is not appropriate.

When sending emails, please put the subject of your message in the subject line so we can process it more efficiently. Also, be sure to put your name and return telephone number in the body of the message.

Communications relating to diagnosis and treatment will be filed in your medical record.

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of email, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email corporate property and your messages may be monitored. Even when emailing from home, you may feel that access to your email is not well controlled, so you should take that into consideration. In addition, you should be aware that, although addressed to me, my staff and/or colleagues would have access to this information.

I understand that this office will not be responsible for information loss or delay, or breaches in confidentiality that are due to technical factors beyond Pure Radiance's control.

I understand and agree to the above email policy, by signing below, you are agreeing that we may send medical related correspondence to you via email, and that we may respond to your emails to us via email.

Patient Signature_____Date _____

No Show/Cancellation Policy

Here at Pure Radiance we strive to be on the cutting edge of technology and treatment to satisfy your needs. It is very important that we provide the best type of care possible for those that seek our services.

In the event that you miss a scheduled appointment, or do not cancel your appointment 24 hours prior, any deposit will be forfeited as a "No Show Fee". A "No Show" prevents us from treating other patients during that time due to the fact that we do not double book procedures. If you cancel your appointment less than 24 hours before, we will require a deposit fee in order to schedule any future appointments.

If you arrive more than 10 minutes late for your scheduled appointment, without prior notice, it will be considered a "No Show." At that time, your deposit will be forfeited as "No Show Fee".

We request that you give us ample notice if you need to cancel or to reschedule your appointment. It is our mission to provide the best possible care and consideration to all patients by scheduling the room for your consultation/treatment as well as providing the service provider for your service(s).

I agree and understand Pure Radiance Med Spa's No Show Policy

Print Name: _____ Client Signature:_____Date:_____

Witness:_____ Date: _____

HIPAA ACCESS FORM FOR PROTECTED HEALTH INFORMATION

I understand that it is a policy of Pure Radiance Laser Retreat to restrict access to my Protected Health Information. In addition to the caregiver(s) providing health services, I would like for the following person/people to have access to my Private Health Information:

Name(s) (Please Print)	DOB	Information Access Preferences
1. Myself (patient of legal guardian)	N/A	
Clinical Information		
2.		□ All OR □Restricted*
3.		□ All OR □Restricted*
4.		□All OR □Restricted*

*Clinical Info Restricted—If you checked this box above, please specify what clinical information you DO NOT wish to share with the person(s) in the above boxes:

□ Botox □ Laser Hair Removal □ DOT Laser
□ Fillers □ Coolsculpting □ Hormone Replacement Therapy
□ Other _____

Communication:

□ You may leave confidential clinical information on my answering machine
□ You may send me email: **Email:** _____
□ You may send me text message confirmations: **Cell Provider** (example: ATT, Verizon) _____

_____ _____ _____
Patient Signature Date Witness Signature

At Pure Radiance, we provide hormone replacement therapy using bio-identical hormone pellets. There are unique advantages to bio-identical hormone pellets compared to other methods such as, pills, shots, patches and creams.

First Step:

To determine if you have symptoms of low hormones, complete our checklist of common symptoms below. If you have several of these symptoms, a lab evaluation is required to make a diagnosis. Blood work is used to evaluate multiple systems, including hormone status. **Second Step:**

A $125.00 fee is required for all new patients. The fee covers new patient set up and the review of lab results by Dr. Stewart.

Third Step:

Once the Doctor reviews your lab results a staff member will contact you with the doctor's recommendations. If you are a candidate for pellet hormone therapy, an appointment will be scheduled. At the appointment, the Doctor with review the test results with you and begin your hormone replacement treatment by placing small hormone pellets under the skin of the hip.

Fourth Step:

- If lab tests have already been performed (within 10 days) by your Doctor, you can provide us a copy.
- Women age 40-50 are required to have a mammogram every 2 years.
- Women age 51 and older are required to have a mammogram every year.
- Women who have not had a hysterectomy are required to have a pap smear every 3 years.
- Women who have had a hysterectomy are not required to have a pap smear.
- All men must have a PSA test every year.

Note:

_____We do not accept health insurance, but upon request can provide you with a letter to file on your own. Some insurance companies cover the treatment.

_____If you do not have insurance or do not want to file your labs through insurance, you may pay the prices listed below at Pure Radiance to cover Lab cost: Pre labs: **$200.00** / Post labs range from: **$75.00 to $200.00**

_____ **WOMEN ONLY*** If you have not had a hysterectomy and/or/are pre-menopausal, you will be required to take a pregnancy test in office before pellet insertion. Pregnancy Test: **$5.00**

_____ **WOMEN ONLY*** It is the patient's responsibility to provide us with copies of your Mammogram, Pap Smear, and labs results prior to booking treatment.

_____**I have received this information and understand the requirements for this treatment.**

Print Name: _____**Date:** _____

Patient Signature: _____

OFFICE USE ONLY

FEMALE INTAKE FORM

NAME: _____ **DOB:** _____ **DATE**: _____

HEIGHT: _____ **WEIGHT:** _____ **ACTIVITY LEVEL:**_____

CURRENT MEDICATIONS: _____

SURGICAL HISTORY: _____

MEDICAL HISTORY: _____

SYMPTOMS:_____

_____

LABS:

Estradiol: _____ Testosterone: _____ Free Testosterone _____ SHBG: _____ FSH: _____

TSH: _____ Free T3: _____ T4 Total: _____ TPO: _____ GFR: _____ HGB: _____ Vitamin D: _____

PLAN:

This patient presents today for hormone pellets. The procedure, risks, benefits and alternatives were explained to the patient. Questions were answered and a consent form for the insertion of Testosterone and/or Estradiol pellet implants was signed. An area in the hip was prepped with Betadine swabs. A sterile drape was applied. 1% Lidocaine with epinephrine and sodium bicarbonate was injected to anesthetize the area. A small transverse incision was made using a number 11 blade. The trocar with cannula was passed through the incision into the subcutaneous tissue. Testosterone and or Estradiol pellet(s) were inserted through the cannula into the subcutaneous tissue. Bleeding was minimal. Steristrips and/or Foam Tape were applied. A sterile dressing was applied. The patient tolerated the procedure well. Postoperative instructions were reviewed and a copy given to the patient. Pellets used are as follows:

DATE: _____ **Right Hip: _____**

TREAT WITH:

1. **Testosterone**: _____ MG **Testosterone Lot Numbers**: _____
2. **Estradiol**: _____ MG **Estradiol Lot Numbers**: _____
3. **Progesterone**: _____ **150 MG** or **200 MG**
4. **DIM**: _____
5. **Vitamin D**: _____
6. **Thyroid:** _____
7. **Iodine:** _____

Other: _____

MEDICAL RECORD OF PELLET INSERTION

DATE ____________________ Weight __________ BP _________ Insertion site: Left Hip _________ Right Hip _______

Nutraceuticals ____

This patient presents today for hormone pellets. Consent, wound care, and follow-up instructions were reviewed with the patient. Insertion site was prepped. Local anesthetic of 1% Lidocaine w/ epi and sodium bicarbonate was injected. A 3mm incision was made using a sterile #11 blade. The hormone implants were inserted using a sterile trocar insertion tool. Pellets used are as follows.

Estradiol ______mg Lot # ___________________________

Testosterone _______mg Lot # ____________________________________ Lot # ____________________________________

Lot # ____________________________________ Lot # _____________________________________

DATE ____________________ Weight __________ BP _________ Insertion site: Left Hip _________ Right Hip _______

Nutraceuticals ____

This patient presents today for hormone pellets. Consent, wound care, and follow-up instructions were reviewed with the patient. Insertion site was prepped. Local anesthetic of 1% Lidocaine w/ epi and sodium bicarbonate was injected. A 3mm incision was made using a sterile #11 blade. The hormone implants were inserted using a sterile trocar insertion tool. Pellets used are as follows.

Estradiol ______mg Lot # ___________________________

Testosterone _______mg Lot # ____________________________________ Lot # ____________________________________

Lot # ____________________________________ Lot # _____________________________________

DATE ____________________ Weight __________ BP _________ Insertion site: Left Hip _________ Right Hip _______

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Estradiol ______mg Lot # ___________________________

Testosterone ______mg Lot # ____________________________________ Lot # ____________________________________

Lot # ____________________________________ Lot # ____________________________________

DATE ____________________ Weight __________ BP _________ Insertion site: Left Hip _________ Right Hip _______

Nutraceuticals ____

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Estradiol ______mg Lot # ___________________________

Testosterone ______mg Lot # ____________________________________ Lot # ____________________________________

Lot # ____________________________________ Lot # ____________________________________

PATIENT NAME____D.O.B.________________