



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:**

Determine if you have symptoms of low hormones by completing our check list of common symptoms. 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. Fee covers new patients 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 will 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 by your Doctor, you can provide us a copy.
- All men must have a PSA test every year.

**Note:**

\_\_\_\_\_ It is the patient's responsibility to provide us with copies of your Mammogram, Pap Smear, and any labs results (if needed) ordered from anyone other than Dr. Mack Stewart.

\_\_\_\_\_ We do not accept health insurance, but upon request can provide you with a letter to file on you own. Some 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

\_\_\_\_\_ I have received this information and understand the requirements for this treatment.

**Print Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

## 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.

We look forward to partnering with you to help you feel your best again.

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.

**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.**

### Pre Labs Needed:

- Estradiol
- Testosterone Free & Total
- PSA Total
- TSH
- T3, Free
- Prolactin
- TPO
- CBC
- Complete Metabolic Panel
- Vitamin D

### Male Post Insertion Labs Needed at 4 Weeks:

- Estradiol
- Testosterone Free & Total
- PSA Total (If PSA was borderline on first insertion)
- CBC



## Male 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 / Other: \_\_\_\_\_

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 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.

### Activity Level:

- ( ) Sedentary
- ( ) Moderate
- ( ) Athletic

### 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.



## 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.                  | ( ) Testicular or prostate cancer.                             |
| ( ) High cholesterol.                     | ( ) Elevated PSA.                                              |
| ( ) Heart Disease.                        | ( ) Prostate enlargement.                                      |
| ( ) Stroke and/or heart attack.           | ( ) Trouble passing urine or take Flomax or Avodart.           |
| ( ) Blood clot and/or a pulmonary emboli. | ( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis). |
| ( ) Hemochromatosis.                      | ( ) Diabetes.                                                  |
| ( ) Depression/anxiety.                   | ( ) Thyroid disease.                                           |
| ( ) Psychiatric Disorder.                 | ( ) Arthritis.                                                 |
| ( ) Cancer (type): _____                  | Year: _____                                                    |

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



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

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

| Symptom (please check mark)                    | Never | Occasionally | Frequently |
|------------------------------------------------|-------|--------------|------------|
| 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/Fatigue            |       |              |            |
| 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               |       |              |            |

Other symptoms that concern you:

|  |
|--|
|  |
|  |
|  |

## Family History

|                     | NO | YES |
|---------------------|----|-----|
| Heart Disease       |    |     |
| Diabetes            |    |     |
| Osteoporosis        |    |     |
| Alzheimer's Disease |    |     |



## Hormone Replacement Fee Acknowledgment

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.

This practice 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.

**New Patient Consult Fee ..... \$125.00**

**Male Hormone Pellet Insertion Fee..... \$625.00**

**Male Hormone Pellet Insertion Fee (over 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



## 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.
- **MOOD SWINGS/IRRITABILITY:** These may occur if you were quite deficient in hormones. They will disappear when enough hormones are in your system.
- **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.

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Print Name

Signature

Today's Date



## Testosterone and/or Estradiol Pellet Insertion Consent Form

Bio-identical testosterone pellets are concentrated, compounded 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 made from soy and are FDA monitored but not approved for male hormone replacement. Hormone replacement using pellets has been used in Europe, the US 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 with pellets.

**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 and are included in the list of overall risks below:**

Bleeding, bruising, swelling, infection and pain. 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. There can also be a 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 rectal exam and 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 & 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 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 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. I understand that Pure Radiance does not guarantee the results of this therapy, and I acknowledge that a refund will not be provided in the event that the desired outcome is not achieved.

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Print Name

Signature

Today’s Date