770 Old Liberty Rd. Ste3 Eldersburg, MD 21784 Phone: 410-970-8480

Name: _____ Date of birth: _____

# FEMALE NEW PATIENT PACKAGE

## The contents of this package are your first step to restoring your vitality. Please take 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 initial blood work panel must include the following tests but additional tests may be added if you have certain other symptoms or conditions:**

- Estradiol _____
- FSH _____
- Testosterone total _____
- T3, free _____
- T4, total _____
- TSH _____
- Tpo (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) _____

**Female post-insertion labs needed at 4 or 6 weeks based on your practitioner's choice:**

- FSH _____
- Testosterone total _____
- Estradiol _____
- Free T3, free T4, TSH (only if you've been prescribed thyroid medication) _____

# FEMALE HEALTH ASSESSMENT QUESTIONNAIRE

NAME: _____ EMAIL: _____

TODAY'S DATE: _____ PHONE: _____

Please mark the appropriate box for each symptom you may be experiencing.

| SYMPTOMS | NONE | MILD | MODERATE | SEVERE | VERY SEVERE |
|---|---|---|---|---|---|
| Physical Exhaustion (fatigue, lack of energy, stamina or motivation) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sleep Problems (difficulty falling asleep or sleeping through the night) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Irritability (mood swings, feeling aggressive, angers easily) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Anxiety (feeling overwhelmed, feeling panicky, or feeling nervous) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Decline in drive or interest (loss of "zest for life," feeling down or sad) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Joint and muscular symptoms (joint pain, muscle weakness, poor recovery after exercise) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Difficulties with memory (concentration, finding the right word, or retaining information) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Vaginal dryness or difficulty with sexual intercourse | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sexual Problems (change in desire, activity, orgasm and/or satisfaction) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sweating (night sweats or increased episodes of sweating) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hot Flashes (burst that starts in chest and lasts for short duration) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hair loss, thinning or change in texture of hair | ☐ | ☐ | ☐ | ☐ | ☐ |
| Feeling cold all the time, having cold hands or feet | ☐ | ☐ | ☐ | ☐ | ☐ |
| Headaches or migraines (increase in frequency or intensity) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Weight (difficulty losing weight despite diet/exercise) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Bladder problems (difficulty in urinating, increased need to urinate, incontinence) | ☐ | ☐ | ☐ | ☐ | ☐ |

**Other symptoms or unique health circumstances to take into consideration:**

770 Old Liberty Rd. Ste3 Eldersburg, MD 21784 Phone: 410-970-8480

Name: _____ Date of birth: _____

# 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 consult visit fee ..... $ 150.00

Female hormone pellet insertion fee ..... $ 425.00

We accept the following forms of payment:

Cash, Check, and Credit Card (with a 3% surcharge added)

Print name: _____

Signature: _____ Date: _____

770 Old Liberty Rd. Ste3 Eldersburg, MD 21784 Phone: 410-970-8480

Name: _____ Date of birth: _____

Date: _____ Diagnosis: ICD10 _____

Re: Reimbursement for services

# FEMALE 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 and/or ☐ Menopause

Her lab values indicate significant androgen and/or estrogen deficiency. Prior to pellet therapy, the patient experienced:

☐ 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 help improve her quality of life both physically and mentally and has benefited her overall well-being. Please honor her request for reimbursement.

Sincerely,

_____

Doctor or clinic name

770 Old Liberty Rd. Ste3 Eldersburg, MD 21784 Phone: 410-970-8480

Name: _____ Date of birth: _____

# 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 health-care 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 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: _____

770 Old Liberty Rd. Ste3 Eldersburg, MD 21784 Phone: 410-970-8480

Name: _____ Date of birth: _____

# FEMALE 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.

770 Old Liberty Rd. Ste3 Eldersburg, MD 21784 Phone: 410-970-8480

Name: _____ Date of birth: _____

# FEMALE 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:**

- ☐ Breast cancer
- ☐ Uterine cancer
- ☐ Ovarian cancer
- ☐ Polycystic ovaries/PCOS
- ☐ Acne
- ☐ Excess facial/body hair
- ☐ Infertility
- ☐ Endometriosis
- ☐ Epilepsy or seizures
- ☐ Fibrocystic breast or breast pain
- ☐ Uterine fibroids
- ☐ Irregular or heavy periods
- ☐ Menstrual migraines
- ☐ Hysterectomy with removal of ovaries
- ☐ Partial hysterectomy (uterus only)
- ☐ Ophorectomy removal of ovaries only

**Birth control method:**

- ☐ Menopause
- ☐ Hysterectomy
- ☐ Tubal ligation
- ☐ Birth control pills
- ☐ Vasectomy
- ☐ IUD
- ☐ Infertility
- ☐ Other _____

770 Old Liberty Rd. Ste3 Eldersburg, MD 21784 Phone: 410-970-8480

Name: _____ Date of birth: _____

# FEMALE 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 _____

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Name: _____ Date of birth: _____

# FEMALE FLOW CHART FOR LAB RESULTS & BIOTE DOSAGES

Medical history (check all that apply) ☐ Facial hair/acne ☐ PCOS ☐ Hair loss/thinning ☐ Endometriosis

☐ Fibroids ☐ Fibrocystic breast ☐ Breast pain ☐ Breast cancer ☐ Seizures ☐ Prior hysterectomy

| Date | FSH | Estradiol | Total testost. (ng/dl) | E2 mg used | Testost. mg used | Comments |
|---|---|---|---|---|---|---|
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770 Old Liberty Rd. Ste3 Eldersburg, MD 21784 Phone: 410-970-8480

Name: _____ Date of birth: _____

# PELLET INSERTION CONSENT FOR FEMALES

My physician/practitioner has recommended bioidentical hormone therapy delivered by a pellet inserted under my skin for treatment of symptoms I am experiencing related to low hormone levels.
The following information has been explained to me prior to receiving the recommended therapy.

OVERVIEW
Bioidentical hormones are hormones that are biologically identical to that made in my own body. The levels of active estradiol and/or testosterone made by my body have decreased, and therapy using these hormones may have the same or similar effect(s) on my body as my own naturally produced hormones. The pellets are a delivery mechanism for estradiol and/or testosterone, and bioidentical hormone replacement therapy using pellets has been used since the 1930's. There are other formulations of estradiol and testosterone replacement available, and different methods can be used to deliver the therapy. There are no commercially available forms of testosterone, however, that are formulated specifically for use in women. The risks associated with pellet therapy are generally similar to other forms of replacement therapy using bioidentical hormones.

PELLET ACTIVE INGREDIENTS
I understand that (please initial by the appropriate statement):

_____ I am receiving pellets today that contain testosterone only.

_____ I am receiving pellets today that contain estradiol and testosterone.

_____ I am receiving pellets today that contain testosterone and anastrozole.

RISKS/COMPLICATIONS OF TESTOSTERONE
Risks associated with pellet insertion may include: bleeding from incision site, bruising, fever, infection, pain, swelling, pellet extrusion which may occur several weeks or months after insertion, reaction to local anesthetic and/or preservatives, allergy to adhesives from bandage(s), steri strips or other adhesive agents.

Some individuals may experience one or more of the following complications with testosterone: acne, abnormal bleeding or a change in menstrual cycle (if patient has a uterus), anxiety, breast or nipple tenderness or swelling, insomnia, depression, mood swings, fluid and electrolyte disturbances, headaches, increase in body hair, fluid retention or swelling, mood swings or irritability, rash, redness, itching, lack of effect (typically from lack of absorption), transient increase in cholesterol, nausea, retention of sodium, chloride and/or potassium, weight gain or weight loss, thinning hair or female pattern baldness, hypersexuality (overactive libido) or decreased libido, overproduction of estrogen (called aromatization) or an increase in red blood cell formation or blood count (erythrocytosis). The latter can be diagnosed with a blood test called a complete blood count (CBC). This test should be done at least annually. Erythrocytosis can be reversed simply by donating blood periodically, but further workup or referral may be required if a more worrisome condition is suspected.

If you are planning to start or expand your family soon, please talk to your provider about other options.

RISKS/COMPLICATIONS OF ESTRADIOL (ONLY APPLICABLE IF RECEIVING ESTRADIOL IN THE PELLETS)
The side-effects of estradiol are similar to those listed above for testosterone. Additionally, there is some risk, even when using bioidentical hormones, that estrogens may cause existing cases of some breast cancers to grow more rapidly. This risk may also apply to some undiagnosed forms of breast cancer.

Using estrogen-alone (without progesterone) may increase the chance of getting cancer of the uterus. Endometrial sampling (biopsy) or surgery may be required if abnormal bleeding occurs.

Please initial if you are postmenopausal, have a uterus, and are getting estradiol.

_____ I understand that I have a uterus and am receiving postmenopausal dosing of estradiol. I agree to take progesterone as directed by my health care provider while receiving estradiol.

RISKS/COMPLICATIONS OF ANASTROZOLE (ONLY APPLICABLE IF RECEIVING ANASTROZOLE IN THE PELLETS)
Anastrozole is a type of medication called an aromatase inhibitor. Aromatase inhibitors limit or prevent the conversion of testosterone into estrogen. Aromatase inhibitors can be used for a variety of conditions but are most commonly used in patients with a history of estrogen receptor positive breast cancer.

Anastrozole should not be used in pregnant women and should be used with caution in women with pre-existing ischemic heart disease. Anastrozole in pellets should not be given to premenopausal women nor to women taking oral aromatase inhibitors (anastrozole or letrozole) or selective estrogen receptor modulators (tamoxifen or raloxifene).

The amount of anastrozole used in pellets is very low. The most common side-effects for women taking anastrozole are hot flashes, joint pain, and muscle pain. Because of the low dose in the pellet, these effects are not usually seen with this type of therapy, however.

CONSENT FOR TREATMENT:
I agree to immediately report any adverse reactions or problems that may be related to my therapy to my physician or health care provider's office, so that it may be reported to the manufacturer. Potential complications have been explained to me, and I acknowledge that I have received and understand this information, including the possible risks and potential complications and the potential benefits.

I also acknowledge that the nature of bioidentical therapy and other treatments have been explained to me, and I have had all my questions answered. I understand that follow-up blood testing will be necessary four (4) weeks after my initial pellet insertion and then at least one time annually thereafter. I also understand that although most patients will receive the correct dosage with the first insertion, some may require dose changes.

I understand that my blood tests may reveal that my levels are not optimal which would mean I may need a higher or lower dose in the future. Furthermore, I have not been promised or guaranteed any specific benefits from the insertion of testosterone pellets.

I accept these risks and benefits, and I consent to the insertion of testosterone pellets under my skin performed by my provider. This consent is ongoing for this and all future insertions in this facility until I am no longer a patient here, but I do understand that I can revoke my consent at any time. I have been informed that I may experience any of the complications to this procedure as described above.

I have read or have had this form read to me.

Witness name: _____ Signature: _____ Date: _____

Print name: _____ Signature: _____ Date: _____

770 Old Liberty Rd. Ste3 Eldersburg, MD 21784 Phone: 410-970-8480

Name: _____ Date of birth: _____

# OFFICE USE ONLY – INITIAL PELLET INSERTION FORM FEMALE

Name: _____ Date: _____ Age: _____

Height: _____ Weight: _____ Blood pressure: _____ Temperature: _____

**Current medications:**

_____

_____

**Surgery/past medical history:** ☐ None

_____

_____

**Symptoms:**

_____

_____

**Lab results:**

FSH: _____ Estradiol: _____ Total testosterone: _____ Vit D: _____ Vit B12: _____

TSH: _____ Free T3:_____ Total T4: _____ TPO: _____ CBC: _____ Chem panel: _____

Total chol: _____ LDL: _____ HDL: _____ Triglycerides: _____

770 Old Liberty Rd. Ste3 Eldersburg, MD 21784 Phone: 410-970-8480

Name: _____ Date of birth: _____

# OFFICE USE ONLY – INITIAL PELLET INSERTION FORM FEMALE CONTINUED

**Procedure note:**

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 pellet implants was signed. The area was prepped with alcohol swabs. Local anesthetic was injected to anesthetize the area. A small incision was made using a #11 blade. The trocar with cannula was passed through the incision into the subcutaneous tissue. Sterile pellet(s) were inserted through the cannula into the subcutaneous tissue. Bleeding was minimal. Steri-strips were applied. A gauze and dressing were applied. The patient tolerated the procedure well. Post-insertion instructions were reviewed, and a copy was given to the patient.

**Prep solution:** ☐ Alcohol ☐ Chloraprep ☐ Other _____

**Local anesthetic:** ☐ 1% lido w/ epi ___ cc ☐ 1% lido ___ cc ☐ Other _____

Sodium bicarbonate ____ cc

**Insertion site:** ☐ Left hip ☐ Right hip ☐ Other _____

**Treat with:**

Testosterone: _____ mg Testosterone lot #: _____

Estradiol: _____ mg Estradiol lot #: _____

Progesterone: _____ mg ☐ Cycle ☐ Continuous

DIM SGS+: _____ ADK 5 or ADK 10: _____ Arterosil: _____

Probiotic: _____ Methyl Factors+: _____ Thyroid RX: _____ mg daily

Iodine+: ☐ ☐ _____ Serene: ☐ _____ Omega 3 + CoQ10: _____

Best Night Sleep: ☐ _____ Senolytic Complex: ☐ _____ BPC-157: ☐ _____

Other: _____

**Labs:** ☐ Due in 6 weeks ☐ Up-to-date ☐ Prior to next insertion

**MAMM:** ☐ Prior to next insertion ☐ Up-to-date

**Yearly:** ☐ Prior to next insertion ☐ Up-to-date

**Comments:**

_____

_____

770 Old Liberty Rd. Ste3 Eldersburg, MD 21784 Phone: 410-970-8480

Name: _____ Date of birth: _____

# OFFICE USE ONLY – REPEAT PELLET INSERTION FORM FEMALE

Name: _____ Date: _____ Age: _____

Weight: _____ BP: _____ Temp: _____ Activity level: _____

**Symptoms/notes:**

_____

_____

**Procedure note:**

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 pellet implants was signed. The area was prepped with alcohol swabs. Local anesthetic was injected to anesthetize the area. A small incision was made using a #11 blade. The trocar with cannula was passed through the incision into the subcutaneous tissue. Sterile pellet(s) were inserted through the cannula into the subcutaneous tissue. Bleeding was minimal. Steri-strips were applied. A gauze and dressing were applied. The patient tolerated the procedure well. Post-insertion instructions were reviewed, and a copy was given to the patient.

**Prep solution:** ☐ Alcohol ☐ Chloraprep ☐ Other _____

**Local anesthetic:** ☐ 1% lido w/ epi ___ cc ☐ 1% lido ___ cc ☐ Other _____

Sodium bicarbonate ____ cc

**Insertion site:** ☐ Left hip ☐ Right hip ☐ Other _____

**Treat with:**

Testosterone: _____ mg Testosterone lot #: _____ Estradiol: _____ mg Estradiol lot #: _____

Progesterone: _____ mg ☐ Cycle ☐ Continuous DIM SGS+: _____ ADK 5 or ADK 10: _____ Arterosil: _____

Probiotic: _____ Methyl Factors+: _____ Thyroid RX: _____ mg daily Iodine+: _____ Serene: _____

Omega 3 + CoQ10: _____ Best Night Sleep: ___ Senolytic Complex: _____ BPC-157: _____ Other: _____

**Labs:** ☐ Due in 6 weeks ☐ Up-to-date ☐ Prior to next insertion

**MAMM:** ☐ Prior to next insertion ☐ Up-to-date **Yearly:** ☐ Prior to next insertion ☐ Up-to-date

**Comments:** _____

770 Old Liberty Rd. Ste3 Eldersburg, MD 21784 Phone: 410-970-8480

Name: _____ Date of birth: _____

# 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 (usually a steri strip) should be removed in 3 days.
- **Do not take tub baths or get into a hot tub or swimming pool for 3-4 days.** You may shower, but do not remove the bandage or steri-strips for 4 days.
- No heavy lifting or major exercises for the incision area for the next 3-4 days, which includes running, 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 (25 to 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. If the redness worsens after the first 2-3 days, please contact the office.
- 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.
- We recommend putting an ice pack on the area where the pellets are located a couple of times for about 20 minutes each time over the next 4 to 5 hours. You can continue this for swelling, if needed. Be sure to place something between the ice pack and your bandages/skin. Do not place ice packs directly on bare skin.

REMINDERS:

- Remember to have your post-insertion blood work done 6 weeks after your FIRST insertion. If you are not feeling any better by 4 weeks, however, please call the office to have your labs drawn early.
- Most women will need re-insertion of their pellets 3-4 months after their initial insertion. If you experience symptoms prior to this, please call the office.
- Please call as soon as symptoms that were relieved from the pellets start to return to make an appointment for your next insertion.

ADDITIONAL INSTRUCTIONS:

_____

_____

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

Print name: _____

Signature: _____ Date: _____

770 Old Liberty Rd. Ste3 Eldersburg, MD 21784 Phone: 410-970-8480

Name: _____ Date of birth: _____

# WHAT MIGHT OCCUR AFTER A PELLET INSERTION (FEMALE)

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.

- INFECTION:
  Is possible with any type of procedure. Infection is uncommon with pellet insertion and occurs in <0.5 to 1%. If redness appears and seems to worsen (rather than improve), is associated with severe heat and/or pus, please contact the office. Warm compresses are helpful, but a prescription antibiotic may also be needed.
- PELLET EXTRUSION:
  Pellet extrusion is uncommon and occurs in <5% of procedures. If the wound becomes sore again after it has healed, begins to ooze or bleed or has a blister-type appearance, please contact the office. Warm compresses may help soothe discomfort.
- ITCHING or REDNESS:
  Itching or redness in the area of the incision and pellet placement is common. If you have a reaction to the tape, please apply hydrocortisone 2-3 times per day to the rash. If redness becomes firm or starts to spread after the first few days, you will need to contact the office.
- FLUID RETENTION/WEIGHT GAIN:
  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, or by taking a mild diuretic, which the office can prescribe.
- BREAST TENDERNESS or SWELLING:
  This usually occurs most commonly in the first round of pellets but does not usually continue thereafter. DIM 1 capsule daily is helpful in preventing this, but the dose may be increased to 2-3 daily, if needed. Evening primrose oil (available in our office) is helpful as is Iodine+ if this occurs.
- MOOD SWINGS/IRRITABILITY/ANXIETY:
  These may occur if you were quite deficient in hormones. These symptoms usually improve as hormone levels improve. 5HTP can be helpful for this temporary symptom and can be purchased at many health food stores.
- ELEVATED RED CELL COUNT
  (most common in men):
  Testosterone may stimulate growth in the bone marrow of the red blood cells. This condition is called erythrocytosis. Erythrocytosis may also occur in some patients independent of any treatments or medications. If your blood count goes too high, you may be asked to see a blood specialist called a hematologist to make sure there is nothing worrisome found. If there is no cause, the testosterone dose may have to be decreased.
- HAIR LOSS:
  Is rarely due to pellets but can occur in some patients who convert testosterone to DHT. Dosage adjustment generally reduces or eliminates the problem. Prescription medications may be necessary in rare cases. Workup for other causes may also be needed.
- FACIAL BREAKOUT:
  Some pimples may arise if the testosterone levels are either too low or rise rapidly. 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.
- UTERINE SPOTTING/BLEEDING/
  IRREGULAR PERIODS:
  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.
- HAIR GROWTH:
  Testosterone may stimulate some growth of hair on your chin, chest, nipples and/or lower abdomen. This tends to be hereditary. Fine, vellous hairs or “peach fuzz” often occurs but is not thick nor coarse. You may also have to shave your legs and arms more often. Dosage adjustment generally reduces or eliminates the problem.

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

Print name: _____

Signature: _____ Date: _____

770 Old Liberty Rd. Ste3 Eldersburg, MD 21784 Phone: 410-970-8480

Name: _____ Date of birth: _____

# FEMALE TREATMENT PLAN

- The following medications or supplements are recommended in addition to your pellet therapy.
- It is best to take these vitamins and/or supplements after eating.
- **If you are currently taking estrogen replacement, please stop after 3 days; if you are using another form of testosterone, please stop after 7 days.**

SUPPLEMENTS: **These are available in our office for your convenience. For best results, please take the supplements recommended for you. Take all supplements or vitamins AFTER a meal.**

_____ DIM SGS+ - take 1 daily.

_____ ADK 5 or _____ ADK 10 - take 1 daily or as directed.

_____ Multi-Strain Probiotic 20B - take 1 to 2 weekly then increase after 1 month to 1 daily.

_____ Bacillus Coagulans - take 1 daily or as directed.

_____ Methyl Factors+ - take 1 daily or as directed based on B12 or other lab results.

_____ Iodine+ - start by taking 2-3x weekly and gradually increase to daily dosing; start Iodine+ about 4 weeks after your first round of pellets.

_____ Arterosil - take 1 capsule twice daily; take 1 capsule 3x daily if taking for diabetic neuropathy.

_____ Curcumin SF - take 1-2 twice daily.

_____ Omega 3 + CoQ10 - take 1-2 twice daily.

_____ Senolytic Complex - take 1 capsule per day with water or as directed.

_____ Best Night Sleep - take 1 capsules 30 minutes before bed or as directed.

_____ Serene - take 1 or 2 capsules with water as needed. Effects typically start to diminish after 3-4 hours. Dosing may vary.

_____ BPC-157 - take 2 capsules per day with water or as directed.

_____ Other _____

PRESCRIPTIONS: **These have been called into your preferred pharmacy**

_____ Progesterone _____ 200 mg generic OR _____ 225 mg compounded OR _____ 100 mg cmpd sublingual.

**If you are POSTMENOPAUSAL, have a uterus, and received estrogen replacement, please do not skip doses of progesterone as it can result in vaginal bleeding or an increased risk for endometrial cancer.**

_____ NP Thyroid _____ mg every morning on an empty stomach; wait 30 minutes before putting anything else on your stomach including coffee, food, or other medications.

_____ Wean off Synthroid/Levothyroxine: alternate your desiccated thyroid (NP Thyroid or Armour) every other day with Synthroid/Levothyroxine for 3 weeks then go to every day on your desiccated thyroid.

_____ Spironolactone 100 mg daily; start with 1/2 tablet daily and increase slowly to daily use in AM.

_____ Wean off your antidepressant (see wean protocol) _____ Other _____

**Please call or email for any questions about these recommendations.**

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Signature: _____ Date: _____

770 Old Liberty Rd. Ste3 Eldersburg, MD 21784 Phone: 410-970-8480

Name: _____ Date of birth: _____

# REQUEST TO RESTRICT DISCLOSURE TO HEALTH PLAN

Authorized by Section 13405(a) of the HITECH Act

I, _____

request that my treating provider(s) and clinic (listed above) not disclose my protected health information (PHI) to my health plan or other third party insurance carrier. Pursuant to Section 13405(a) of the HITECH Act, I understand I have the right to request restrictions on whether the Practice discloses my protected health information (PHI) with my health plan and the Practice is required to agree to my request unless the information is required to be disclosed to my health plan to comply with the law.

The records of the restricted services/items listed below ("Restricted Services/Items") will not be released or billed to my health plan or other third party insurance carrier for the purposes of payment or health care operations. I understand I am financially responsible for these Restricted Services/Items and will pay out-of-pocket, in full, at the time of service in order for the Practice to accept this restriction request.

## REQUESTED RESTRICTION:

Services/Items to be restricted: _____ subcutaneous pellet hormone replacement: _____

_____

Total charge amount (or estimated amount): $ _____ per treatment/per month (circle one)

Other: _____

I understand that I am responsible personally for full charges when finalized.

Patient name (please print): _____

Signature: _____

Date: _____

## PRACTICE USE ONLY:

Witness name (please print): _____

Signature: _____

Date: _____