770 Old Liberty Rd. Ste. 3 Eldersburg, MD 21784 Phone: 410-970-8480

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 _____

MALE 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 (poor recovery after workout, inability to add muscle, joint pain, muscle weakness)	☐	☐	☐	☐	☐
Difficulties with memory (concentration, finding the right word, or retaining information)	☐	☐	☐	☐	☐
Sexual Desire or Performance (reduced or diminished)	☐	☐	☐	☐	☐
Erectile changes (weaker erections, loss of morning erections)	☐	☐	☐	☐	☐
Ejaculations (infrequent or absent)	☐	☐	☐	☐	☐
Sweating (night sweats or increased episodes of sweating)	☐	☐	☐	☐	☐
Hair loss, rapid or thinning	☐	☐	☐	☐	☐
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)	☐	☐	☐	☐	☐

Other symptoms or unique health circumstances to take into consideration:

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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

Male hormone pellet insertion fee ..... $ 750.00

We accept the following forms of payment:

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

Print name: _____

Signature: _____ Date: _____

770 Old Liberty Rd. Ste. 3 Eldersburg, MD 21784 Phone: 410-970-8480

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

770 Old Liberty Rd. Ste. 3 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 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: _____

770 Old Liberty Rd. Ste. 3 Eldersburg, MD 21784 Phone: 410-970-8480

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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Name: _____ Date of birth: _____

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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Name: _____ Date of birth: _____

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 _____

770 Old Liberty Rd. Ste. 3 Eldersburg, MD 21784 Phone: 410-970-8480

Name: _____ Date of birth: _____

MALE FLOW CHART FOR LAB RESULTS & BIOTE DOSAGES

Medical history (check all that apply): ☐ BPH ☐ Elevated PSA ☐ Prostate cancer

Date	Total testost. (ng/dl)	Free testost. (ng/dl)	E2 level (pg/ml)	PSA	Testost. mg used	Comments

770 Old Liberty Rd. Ste. 3 Eldersburg, MD 21784 Phone: 410-970-8480

Name: _____ Date of birth: _____

PELLET INSERTION CONSENT FOR MALES

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

OVERVIEW

Bioidentical testosterone is a form of testosterone that is biologically identical to that made in my own body. The levels of active 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 testosterone. The pellets are a delivery mechanism for testosterone, and bioidentical hormone replacement therapy using pellets has been used since the 1930's. There are other formulations of testosterone replacement available, and different methods can be used to deliver the therapy. The risks associated with pellet therapy are generally similar to other forms of replacement therapy using bioidentical hormones.

RISKS/COMPLICATIONS

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: acne, 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 male pattern baldness, increased growth of prostate and prostate tumors which may or may not lead to worsening of urinary symptoms, hypersexuality (overactive libido) or decreased libido, erectile dysfunction, painful ejaculation, ten to fifteen percent shrinkage in testicular size, and/or significant reduction in sperm production, increase in neck circumference, 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.

All types of testosterone replacement can cause a significant decrease in sperm count during use. Pellet therapy may affect sperm count for up to one year. If you are planning to start or expand your family, please talk to your provider about other options.

Additionally, there is some risk, even when using bioidentical hormones, that testosterone therapy may cause existing cases of prostate cancer to grow more rapidly. For this reason, a prostate specific antigen blood test (PSA) is recommended for men ages 55-69 before starting hormone therapy, even if asymptomatic. Testing is also recommended for younger individuals considered high risk for prostate cancer. The test should be repeated each year thereafter. If there is any question about possible prostate cancer, a follow-up referral to a qualified specialist for further evaluation may be required.

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 have read or have had this form read to me.

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.

Witness name: _____ Signature: _____ Date: _____

Print name: _____ Signature: _____ Date: _____

770 Old Liberty Rd. Ste. 3 Eldersburg, MD 21784 Phone: 410-970-8480

Name: _____ Date of birth: _____

OFFICE USE ONLY – INITIAL PELLET INSERTION FORM MALE

Name: _____ Date: _____ Age: _____

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

Current medications:

_____

_____

Surgery/past medical history: ☐ None

_____

_____

Symptoms:

_____

_____

Lab results:

Estradiol: _____ Testosterone: _____ Free test: _____ PSA: _____ Vitamin D: _____

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

LDL: _____ HDL: _____ Triglycerides: _____ Prolactin (<40 y/o): _____

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Name: _____ Date of birth: _____

OFFICE USE ONLY – INITIAL PELLET INSERTION FORM MALE CONTINUED

Procedure note:

The procedure, risks, benefits and alternatives were explained to the patient. Questions were answered and a consent form for the insertion of testosterone pellet implants was signed. An area was prepped. The area was then infiltrated with local anesthesia. A small incision was made using a #11 blade scalpel. The trocar with cannula was passed through the incision into the subcutaneous tissue. Testosterone pellet(s) were inserted through the cannula into the subcutaneous tissue. Bleeding was minimal. Steri-strips were applied. A sterile dressing was 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 #: _____

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 4 weeks ☐ Up-to-date ☐ Prior to next insertion

Prostate exam: ☐ Prior to next insertion ☐ Up-to-date ☐ Not applicable

Comments:

_____

_____

770 Old Liberty Rd. Ste. 3 Eldersburg, MD 21784 Phone: 410-970-8480

Name: _____ Date of birth: _____

OFFICE USE ONLY - REPEAT PELLET INSERTIONS FORM MALE

Name: _____ Date: _____ Age: _____

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

Symptoms/notes:

_____

_____

Procedure note:

The procedure, risks, benefits and alternatives were explained to the patient. Questions were answered and a consent form for the insertion of testosterone pellet implants was signed. An area was prepped. The area was then infiltrated with local anesthesia. A small incision was made using a #11 blade scalpel. The trocar with cannula was passed through the incision into the subcutaneous tissue. Testosterone pellet(s) were inserted through the cannula into the subcutaneous tissue. Bleeding was minimal. Steri-strips were applied. A sterile dressing was 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 #: _____ 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 4 weeks ☐ Up-to-date ☐ Prior to next insertion

Prostate exam: ☐ Prior to next insertion ☐ Up-to-date ☐ Not applicable

Comments:

_____

770 Old Liberty Rd. Ste. 3 Eldersburg, MD 21784 Phone: 410-970-8480

Name: _____ Date of birth: _____

POST-INSERTION INSTRUCTIONS FOR MEN

- Your insertion site has been covered with two layers of bandages. The inner layer is a steri-strip, and the outer layer is a waterproof dressing.
- **Do not take tub baths or get into a hot tub or swimming pool for 7 days.** You may shower, but do not remove the bandage or steri-strips for 7 days.
- No major exercises for the incision area. No heavy lifting using the legs for 7 days. This includes running, elliptical, squats, lunges, etc. You can do moderate upper body work and normal walking on a flat surface.
- 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. 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 oozing) not relieved with pressure, 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 4 weeks after your FIRST insertion.
- Most men will need re-insertion of their pellets 4-5 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. Ste. 3 Eldersburg, MD 21784 Phone: 410-970-8480

Name: _____ Date of birth: _____

WHAT MIGHT OCCUR AFTER A PELLET INSERTION (MALE)

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:
  Infection is a possibility 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. Some patients may also have a reaction to the tape or glue. If this occurs, apply hydrocortisone to the area 2-3 times daily. If the redness becomes firm or starts to spread, please 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 NIPPLE SENSITIVITY:
  These may develop with the first pellet insertion. The increase in estrogen sends more blood to the breast tissue. Increased blood supply is a good thing, as it nourishes the tissue. Taking 2 capsules of DIM daily helps prevent excess estrogen formation. In males, this may indicate that you are a person who is an aromatizer (changes testosterone into estrogen). This is usually prevented if DIM is taken regularly but can be easily treated and will be addressed further when your labs are done, if needed.
- MOOD SWINGS/IRRITABILITY:
  These may occur if you were quite deficient in hormones. These symptoms usually improve when enough hormones are in your system. 5HTP can be helpful for this temporary symptom and can be purchased at many health food stores.
- ELEVATED RED BLOOD CELL COUNT:
  Testosterone may stimulate growth in the bone marrow of the red blood cells. This condition 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. Routine blood donation may be helpful in preventing this.
- HAIR LOSS OR ANXIETY:
  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. 5HTP may be helpful for anxiety and is available over-the-counter.
- FACIAL/BODY BREAKOUT:
  Acne may occur when testosterone levels are either very low or high. 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.
- AROMATIZATION:
  Some men will form higher-than-expected levels of estrogen from the testosterone. Using DIM 2 capsules daily as directed may prevent this. Symptoms such as nipple tenderness or feeling emotional may be observed. These will usually resolve by taking DIM, but a prescription may be needed.
- HIGH OR LOW HORMONE LEVELS:
  The majority of times, we administer the hormone dosage that is best for each patient, however, every patient breaks down and uses hormones differently. Most patients will have the correct dosage the first insertion, but some patients may require dosage changes and blood testing. If your blood levels are low, results are not optimal and it is not too far from the original insertion, we may suggest you return so we can administer additional pellets or a “boost” (at no charge). This would require blood work to confirm. On the other hand, if your levels are high, we can treat the symptoms (if you are having any) by supplements and/or prescription medications. The dosage will be adjusted at your next insertion.
- TESTICULAR SHRINKAGE:
  Testicular shrinkage is expected with any type of testosterone treatment.
- LOW SPERM COUNT:
  Any testosterone replacement will cause significant decrease in sperm count during use. Pellet therapy may affect sperm count up to one year. If you are planning to start or expand your family, please talk to your provider about other options.

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

Print name: _____

Signature: _____ Date: _____

770 Old Liberty Rd. Ste. 3 Eldersburg, MD 21784 Phone: 410-970-8480

Name: _____ Date of birth: _____

MALE 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 using another form of testosterone, please stop after 7 to 10 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 2 daily, 1 in AM and 1 in PM.

_____ 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 in to your preferred pharmacy.**

_____ 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) every other day with Synthroid/ Levothyroxine for 3 weeks then go to every day on your desiccated thyroid.

_____ Femara (letrozole) 2.5 mg _____ tablet every _____ week(s).

_____ Arimidex (anastrazole) 1 mg _____ tablet every _____ week(s).

_____ Wean off your antidepressant (see wean protocol) once you are feeling better in 4-6 weeks.

_____ Other _____

Please call or email for any questions about these recommendations.

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Signature: _____ Date: _____

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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: _____