Philip Borgardt, M.D. Inc.
Consent for Treatment

I, _________________________, agree to proceed with treatment by Philip Borgardt, MD. I understand that Dr. Borgardt has a strictly consultative practice. To this end, I understand that to remain a patient in this practice, I must agree to accept the responsibility to obtain and keep current a relationship with a primary care physician or gynecologist to provide routine physical examination and evaluation services. Documentation of such treatment will be requested as indicated.

In addition, I understand that many of the treatment protocols and medications that are recommended by Dr. Borgardt in the course of my care may be characterized as alternative in nature, outside the "standard of care," or off FDA label for a specific indication. I understand that each such incidence will be discussed with me fully at the time of our visit, so that I may have full benefit of comprehensive informed consent.

Potential risks, benefits and the limitations of current research on any particular treatment option will be discussed with me at length. I understand I have the right to decline treatment at any time and that I can request review of the informed consent process as needed. I understand that it is impossible to predict all risks/outcomes when dealing with new therapies and agree to assume these risks.

I also agree to abide by Dr. Borgardt's recommendations for follow up appointments, as they are often determined by clinical protocols and the need for careful monitoring when dealing with newer therapies.

Signature: Date:

Print name:

SLO: 865 Aerovista Place, Ste 210, San Luis Obispo, CA 93401 Ph: 805-540-5544 Fax: 805.528-1690
BAY AREA: 3860 Blackhawk Rd. Ste 140, Danville, CA 94506 Ph: 925-951-3359 Fax: 805.528-1690

Philip Borgardt, M.D. Inc.

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I can receive a copy of Dr. Borgardt's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is available from the receptionist and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Authorization to Release Medical Information / Records

I hereby request that Dr. Borgardt has authorization to request any records and/or information necessary to complete treatment on my behalf. I also authorize Dr. Borgardt to provide in writing to my doctor, hospital, a report of my diagnosis, treatment, prognosis and recommendations, as well as other data pertinent to this treatment of me. This authorization will remain valid until revoked in writing by myself.

Authorization for Records Request

I hereby authorize the release of my medical records to:

Philip Borgardt M.D., Inc.
865 Aerovista Place, Suite 210
San Luis Obispo, CA 93401
Ph: 805-540-5544
Fax: 805-528-1690

Signature: ______________________ Date: ______________

Print name: ______________________

Philip Borgardt, M.D. Inc.

Medicare Notification Form

Philip Borgardt, MD Inc. and TNC, Inc. are NOT Medicare providers.

- ☐ **NO**, I am NOT on Medicare
- ☐ **YES**, I am on Medicare

You will be responsible to pay for the medical services provided. Medicare will not reimburse you and you can not submit bills to Medicare.

We *will not* be supplying you with a Superbill or a Statement for services.

By signing below you agree:

I understand I *will not be provided* with a Superbill to submit to Medicare and I *will not* try to bill Medicare on my own.

Name ____Date_________________

Philip Borgardt, M.D. Inc.

BIO-IDENTICAL HORMONE REPLACEMENT THERAPY INFORMED CONSENT

I understand that natural or bio-identical hormone replacement therapy (BHRT) is the therapeutic use of hormones identical to the hormones made naturally by the body. These hormones are typically used to treat symptoms of premenstrual syndrome (PMS), pre-menopause, peri-menopause, menopause, post-menopause, andropause (male menopause), thyroid dysfunction and adrenal fatigue. Other symptoms and health concerns may also be treated with BHRT.

I understand that it is my responsibility to have an annual physical examination, annual gynecological exam/breast exam/mammogram or equivalent (for males, i.e. prostate exam), including any suggested laboratory tests to ensure that I have no disease(s) which might make natural BHRT inappropriate for my condition.

I also understand that BHRT requires laboratory monitoring as prescribed by my physician or healthcare provider. I understand that bio-identical estrogen potentially has the same cancer risk as the estrogen produced within my own body and should never be used without bio-identical progesterone, unless a hysterectomy has been performed. Personal family history of breast, ovarian, or endometrial (uterine) cancer should be discussed with your healthcare provider. For male patients, studies have shown testosterone does not increase risk of prostate cancer. A large majority of Testosterone Replacement Therapy studies show improved heart health, and decreased risk of heart attack.

I understand that BHRT does not increase heart disease if given at the proper dosage and ratio. Patients with previous deep vein thrombosis (DVT), or blood clots, require careful monitoring if they are taking oral estrogen. Women or men with known heart disease or other serious illness need routine evaluation and annual labs including cholesterol levels, EKG, and other necessary tests. Patients are encouraged to follow up with their primary care physician for these conditions. BHRT taken transdermally (through the skin) does not increase risks of blood clots or DVT.

I hereby release Philip Borgardt, MD., FACP, his associates, and TNC Inc. Weight Loss from any and all liability associated or connected with my consultation, recommendations, and/or use of BHRT. I hereby state that I am aware of the potential benefits and side effects associated with BHRT.

I understand that no doctor, nurse, dispensary, or administrative personal can guarantee that BHRT, even if prescribed, will provide the results I desire. I understand that lifestyle modifications, proper nutrition and supplementation, adequate sleep, and stress reduction are all key components to a successful BHRT regimen.

__________________________________ __________________________________
Patient Name – Please Print   Date

__________________________________ __________________________________
Patient Signature   Witness Signature

Philip Borgardt, M.D. Inc.

Office Charges and Appointment Policy

New Patient Initial Visit Fees

- Hormone Replacement Therapy Appointment - $200.00
- New Patient Appointment Phone $205.00

Phone Appointments

Please CALL OUR OFFICE at your scheduled appointment time, to avoid missed appointment fees.

Follow Up Visit Fees

Follow up visits are important for your hormone health. Patients who come in as scheduled generally feel better on a daily basis.

- Hormone Replacement Therapy Appointment - $135.00
- Follow Up Phone Appointment - $ 140.00
- Combined Hormone/Weight Loss Appointment- $ 145.00
- Phone Combo Appointment - $150.00

Restart Fee

If a client has dropped out of treatment or has missed or canceled appointments for at least 6 months after the most recent recommended follow –up visit there is a Restart Fee.

(If there are circumstances outside of your control please discuss your problem with Dr. Borgardt)

- Hormone Replacement Therapy Restart Appointment - $160.00
- Hormone Replacement Therapy Restart Phone - $165.00

Due to the large number of last minute cancellations, we regret we need to implement our new cancellation fee policy. Please understand there are many patients who would be happy to fill your appointment if given enough notice.

Missed/Canceled Appointment Fees

We require at least 24 hours notice for a cancellation.

- If you do not notify our office 1 full business day before your appointment a $35.00 cancellation fee will be charged.
- $60.00 missed appointment fee.
- Please make every effort to arrive on time
  (We try to keep on schedule out of respect for your time as much as our own).

Refills of Prescriptions

Prescription refills will only be made at your appointment with Dr. Borgardt.
You will be given a new prescription, to last through your next visit, at each visit.
I have read the above policy and agree to abide by the policy and charges.

Signature____ **Date**___________________

Philip Borgardt, M.D. Inc.

New Patient Registration and Medical Health History Questionnaire

NAME: ____ AGE: _______ DATE: _____________

GENERAL HEALTH: GOOD_____ FAIR_____ POOR_____ HEIGHT:____________

PHYSICIANS you are seeing: ____

CURRENT MEDICAL PROBLEMS: ____
____
____

OTHER CONCERNS you would like to discuss with the physician: ______________________________
____

Have you had (circle):	migraines	hepatitis	mono	ulcer
bleeding problem	blood clots	head injury	drug addiction	gallstones
tuberculosis	STDs	seizures	memory trouble	arthritis
psoriasis	heart murmur	rheumatic fever	polio	shingles
alcoholism	depression	mental illness	gout	hemorrhoids
hearing trouble	vision trouble	other	______________	____________

List SURGERIES you have had (include year, surgeon, hospital): ______________________________
____
____
____

List all CURRENT PRESCRIPTION MEDICINES (include dosage, reason you take it, who prescribed it):
____
____
____

List all OVER-THE-COUNTER MEDICINES, vitamins, and food supplements that you take: _______________
____
____

ALLERGIES: ____________________________ SENSITIVITIES: ____________________________
______________________________________ ______________________________________
______________________________________ ______________________________________

Describe HOSPITALIZATIONS/ILLNESSES not included above (include year, hospital): __________________
____
____
____

Philip Borgardt, M.D. Inc.

Who in your *family* has/had (circle if cause of death and write age of death)

heart disease ___________________________________ genetic disorder ____________________________________

diabetes _______________________________________ cancer ____

thyroid disease _______________________________

List any other diseases that run in your family and specify your relationship to each family member listed. ______
____

Where do/did you work? ____

Describe your education/upbringing, etc ____

How much do you weigh? ______ How much would you like to weigh? _______ Heaviest weight ___________

Do/did you EXERCISE? _______ How much? _______ hrs/wk No. of years? _______ Year you QUIT ________

Do/did you SMOKE? ______ How much? ______ packs/day No. of years ______ Year you QUIT ________

Do/did you DRINK alcohol? ______ How much? _________ drinks/week No. of years _____

Year you Quit _________ Previous or current problem with alcohol? __________________ AA? _________

Do/did you use (circle): caffeine artificial sweetener marijuana cocaine chewing tobacco diet pills

Describe your diet. ____
____

Describe any urinary trouble. ____
` ____

Describe sexual concerns. ____
____

Describe any hormone problem. ____
____

Describe any problems with your thinking, concentration, moods, energy level, interest in life, etc. ___________________
____

Describe problems with strength, sensation, coordination, or neurologic function. __________________________________
____

Anything else? ____
____

Please sign and date: ____

Philip Borgardt, M.D. Inc.

Andropause Self Assessment Questionnaire

Patient Name: ____ Date: ____________

Address: ____ DOB: ____________

City: ______________________________ State: ____________ Zip: _____________

Phone: _________________ Fax: __________________ Email: _________________

How did you hear about Us?

Advertisement________________________ Books/Articles_________________________________
Another Patient________________________ Internet_____________________________________
Physician____________________________ Other (please specify)_________________________

Do you understand the risks associated with the use of Natural Hormone Replacement? ___________________
____

What are your goals for Natural Hormone Replacement?____
____

Medical History	Self	Duration	Family History
Cancer (type)_____________	______	______	____________
Heart Disease	______	______	____________
Diabetes	______	______	____________
High Blood Pressure	______	______	____________

Medical History (for SELF)	Yes	No
Persistent Urinary Tract Infections	______	______
Adult Mumps	______	______
Orchitis (testicular inflammation)	______	______
Other Testicular Problems	______	______
Prostate Operation	______	______
Vasectomy	______	______
Impaired Liver Function	______	______
Smoking History	______	______

Philip Borgardt, M.D. Inc.

General Health: Good________ Fair_________ Poor________

Height:____________ **Weight:** ___________

Current Medications (including vitamins, herbals, etc.):____
____

Allergies (drug, food, pollen):____
____

To what degree do you experience the following?

	None	Slightly	Moderate	Severe	Extreme
Fatigue or loss of energy					
Depression, low or negative mood					
Irritability, anger or bad temper					
Anxiety or nervousness					
Lack of motivation					
Loss of memory or concentration					
Impotence					
Inability to ejaculate					
Weight gain					
Backache, joint pains or stiffness					
Loss of muscle mass/tone					

Waiver

I fully understand that it is my responsibility to have an annual physical examination along with appropriate laboratory testing. I hereby state that I am currently under the supervision of a primary care physician. I have been advised in the questionnaire about any risk associated with my use of Biological Identical Hormone Replacement.

Patient Signature____________________________________Date_____________________