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.

Philip Borgardt MD

Authorization to Discuss Medical Information

I authorize Philip Borgardt, MD/TNC to leave detailed messages on my voicemail.

Yes or No (please circle your response)

I authorize Philip Borgardt, MD to discuss my information with*:

Name of friend or family members (printed)	Relationship to patient
_____	_____
_____	_____
_____	_____

(Please cross out anything below you do not wish discussed.)

- Medical conditions
- Appointments
- Prescriptions
- Payments or other issues specified below

_____

_____

Patient name _____ DOB _____
(Please print)

Patient signature _____ Date _____

* It is your responsibility to inform us of any changes in the future.

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.

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.

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 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 personnel 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.

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.

Do you understand what Bio- Identical Hormone Replacement is?_____

What are your goals for Bio-Identical Hormone Replacement?_____

_____

Personal History

- ☐ Heart Disease
- ☐ Fibrocystic Disease
- ☐ Fibroids
- ☐ Diabetes
- ☐ Stroke
- ☐ Impaired Liver Function
- ☐ Endometriosis
- ☐ Cancer (type)_____
- ☐ Osteoporosis
- ☐ High Blood Pressure
- ☐ Thrombophlebitis

Cholesterol:_____Date:_____Results:_____
Bone density scan_____Date:_____Results:_____

Age at first period _____ Date of last normal period _____

No. of pregnancies _____No. of live births _____

No. of children living with you _____ Birth control method _____

Date of last PAP _____ Done where_____

Date of last mammogram _____ Done where _____

Do you have (circle):

irregular periods	bad menstrual cramps	heavy periods
pelvic pain	infertility	abnormal PAP
hot flashes	vaginal dryness	vaginal discharge
vaginal odor	vaginal itching	breast problems
abnormal mammogram		PMS

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Periods:

☐ None ☐ Regular_____

☐ Irregular_____ Explain (heavy, how long, etc)_____

Surgery:

Date of Surgery:

☐ Oopherectomy _____ (uterus & ovaries)

☐ Hysterectomy _____ (uterus only)

☐ Tubal Ligation _____

☐ None

HRT History: (including dates of use) _____

_____

_____

To what degree do you experience the following?

	None	Slightly	Moderate	Severe	Extreme
Difficulty Concentrating					
Can't Sleep (Insomnia)					
Depressed or Unhappy					
Anxious					
Headaches					
Moodiness/Emotional Swings					
Painful or Swollen Breasts					
Weight gain/ Bloating					
PMS					
Night Sweats					
Difficulty Remembering Things					
Hot Flashes					
Vaginal Dryness					
Dry Hair/Skin					
Incontinence					
Frequent Urinary Tract Infections					
Inability to Reach Orgasm					
Painful Intercourse					
Lack of Sexual Desire					
Fatigue/Loss of Energy					

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 Bio-Identical Hormone Replacement.

Patient Signature_____Date_____