BioSana ID Male Patient

Thank you for your interest in BioSana ID. To determine if you are a candidate for Bio-Identical hormone pellets, we need lab test and medical history forms. We will evaluate your information prior to your consultation to determine if BioSana ID can help you live a healthier life.

Prior (2 weeks) to your scheduled consultation, you will need to get your lab drawn at any Clinical Pathology Laboratory (CPL) lab. If you are not insured or have a high deductible, call our office for self-pay blood draw discounts. We need the test listed below to determine if you are a candidate. It is your responsibility to find out if your insurance company will cover the cost, and which lab to go to. Please note that it can take 7 to 10 days for your lab results to be received by our office.

Your lab must include the following test for a Pre and Post Male Panel:

_____ CBC w/ Auto Diff with Platelets

_____ CMP

_____ DHEA

_____ Dihydrotestosterone

_____ Estradiol

_____ PSA, Total

_____ Testosterone

- Free Testosterone (Calculated)
- Sex Hormone Binding Globulin

Post labs needed at 4 weeks. Repeat panel above.

Male Patient Questionnaire & History

Name: _____ Today's Date: _____

(Last) (First) (Middle)

Date of Birth: _____ Age: _____ Weight: _____ Occupation: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work: _____

E-mail Address: _____ May we contact you via E-Mail? ( ) Yes ( ) No

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Primary Care Physician's Name: _____ Phone Number: _____

Address: _____

Address City State Zip Code

Marital Status (check one) ( ) Married ( ) Divorced ( ) Widow ( ) Living with Partner ( ) Single

In the event we cannot contact you by the means of your provided information provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are giving us permission to speak with your spouse or significant other about your treatment.

Spouse's Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Social:

( ) I am sexually active.
( ) I want to be sexually active.
( ) I have completed my family.
( ) I have used steroids in the past for athletic purposes.

Habits:

( ) I smoke cigarettes or cigars _____ a day.
( ) I drink alcoholic beverages _____ per week.
( ) I drink more than 10 alcoholic beverages a week.
( ) I use caffeine _____ a day.

Medical History

Any known drug allergies: _____

Have you ever had any issues with anesthesia? ( ) Yes ( ) No

If yes, please explain: _____

Medications currently taking: _____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Nutritional/ Vitamin Supplements: _____

Surgeries, list all and when: _____

Other pertinent Information: _____

Medical Illnesses:

( ) High Blood Pressure

( ) High cholesterol

( ) Heart Disease

( ) Stroke and/ or heart attack

( ) Blood clot and/ or a pulmonary emboli

( ) Hemochromatosis

( ) Depression/anxiety

( ) Psychiatric Disorder

( ) Cancer (type): _____

Year: _____

( ) Testicular or prostate cancer

( ) Elevated PSA

( ) Prostate enlargement

( ) Trouble passing urine or take Flomax or Avodart

( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis)

( ) Diabetes

( ) Thyroid disease

( ) Arthritis

I understand that if I began testosterone replacement with any testosterone treatment, including testosterone pellets, that I will produce less testosterone from my testicles and if stop replacement, I may experience a temporary decrease in my testosterone production. Testosterone Pellets should be completely out of your system in 12 months.

By beginning treatment, I accept all the risks of therapy stated herein and future risks that might be reported. I understand that higher than normal physiologic levels may be reached to create the necessary hormonal balance.

_____ _____ _____

Print Name Signature Today's Date

Health Assessment for Men

Name: _____ Date: _____

E-mail: _____

Symptom (please check mark)	Never	Mild	Moderate	Severe
Decline in general well being	____	____	____	____
Fatigue	____	____	____	____
Joint pain/muscle ache	____	____	____	____
Excessive sweating	____	____	____	____
Sleep problems	____	____	____	____
Increased need for sleep	____	____	____	____
Irritability	____	____	____	____
Nervousness	____	____	____	____
Anxiety	____	____	____	____
Depressed Mood	____	____	____	____
Exhaustion/ lacking vitality	____	____	____	____
Declining mental ability/focus/concentration	____	____	____	____
Feeling you have passed your peak	____	____	____	____
Feeling burned out/hit rock bottom	____	____	____	____
Decreased muscle strength	____	____	____	____
Weight Gain/ belly fat/ Inability to lose weight	____	____	____	____
Breast development	____	____	____	____
Shrinking testicles	____	____	____	____
Rapid hair loss	____	____	____	____
Decreased in beard growth	____	____	____	____
New migraine headaches	____	____	____	____
Decreased desire/libido	____	____	____	____
Decreased morning erections	____	____	____	____
Decreased ability to perform sexually	____	____	____	____
Infrequent or Absent Ejaculations	____	____	____	____
No results from E.D. Medications	____	____	____	____

Family History

	Yes	No
Heart Disease	____	____
Diabetes	____	____
Osteoporosis	____	____
Alzheimer's Disease	____	____

BioSana ID

INDIVIDUALLY DESIGNED WELLNESS

Prostate Cancer Waiver for Testosterone Pellet Therapy

I, _____, voluntarily choose to undergo implantation of subcutaneous bio-identical pellet therapy with, (Provider) _____. Even though I have history of prostate cancer. I understand that such therapy is controversial and that many doctors believe that testosterone replacement in my case is contradicted. My treating provider has informed me it is possible that taking testosterone could possibly cause cancer, or stimulate existing prostate cancer, including one that has not yet been detected. Accordingly, I am aware that prostate cancer or other cancer could develop while on pellet therapy. I have assessed this risk on a personal basis, and my perceived value of the hormone pellet therapy outweighs the risk in my mine. I am, choosing to undergo the pellet therapy despite the potential risk that I was informed of by my treating provider.

I acknowledge that I bear full responsibility for any personal injury or illness, accident, risk or loss including death and/or prostate issue that may be sustained by me in connection with my decision to undergo testosterone pellet therapy including, without limitation, any caner that should develop on the future, whether it be deemed of a current cancer. I hereby release and agree harmless _____, treating provider, BioSana ID, LLC., and nay of their BioSana ID medical physicians, nurses, officers, directors, employee's and agents from any and all liability, claims, demands and actions arising or related to any loss, property damage, illness, injury or accident that may be sustained by me as a result of testosterone pellet therapy. I acknowledge and agree that I have been given adequate opportunity to review this document and to ask questions. This release and hold harmless agreement is and shall be binding myself and my heirs, assigns and personal representatives.

_____	_____	_____
Patient Print Name	Signature	Date
_____	_____	_____
Provider Print Name	Signature	Date

BioSana ID

INDIVIDUALLY DESIGNED WELLNESS

Prostate Exam Waiver for Testosterone Pellet Therapy

I, _____, voluntarily choose to undergo implantation of subcutaneous bio-identical testosterone pellet therapy with (Provider) _____.

For today's appointment, I have not provided you with a prostate exam report, due to the following reason:

_____ My decision not to have a prostate exam.

_____ I am unable to provide it at this time.

I am aware that a current report must be sent by mail or fax to our office prior to my next HRT appointment. The treating Provider has discussed the importance and necessity of a prostate exam since I received testosterone.

_____ Initials of Patient

A prostate exam is the best single method for detection of early prostate cancer. I understand that my refusal to submit to a prostate exam may results in cancer remaining undetected within my body. Hormone therapy may increase the risk of such undetected cancer.

I acknowledge that I bear full responsibility for any personal injury or illness, accident, risk, or loss including death and/ or prostate issues that my sustained by me in connection with my decision to undergo testosterone pellet therapy including, without limitation, any cancer that should develop in the future,, whether it be deem a stimulation of a current or new cancer. I hereby release and agree to hold harmless _____, treating provider, BioSana ID., LLC and any of their BioSana ID physicians, nurses, officers, directors, employees and agents from any and all liability, claims, demands and actions arising or related to any loss, property damage, illness, injury or accident that may be sustained by me as a results of testosterone pellet therapy. I acknowledge and agree that I have been given adequate opportunity to review this document and to ask questions. This release and hold harmless agreement is and shall be binding on myself and my heirs, assigns and personal representatives.

_____	_____	_____
Patient Print Name	Signature	Date
_____	_____	_____
Provider Print Name	Signature	Date

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 14th, 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 regulations on who may see or be notified of your Protect 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 and 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 yo other communications information 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 you 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.

_____	_____	_____
Print Name	Signature	Date

UTD 11/2018

Testosterone Pellet Insertion Consent Form

Bio-Identical testosterone pellets are concentrated, compounded hormone, biologically identical to the testosterone that is made in your own body. Testosterone was made in your testicles prior to "andropause." Bio-identical hormones have the same effects on your body as your own testosterone did when you were younger. Bio-identical hormone pellets are made from yams and bio-identical hormone replacement using pellets has been used in Europe, The U.S. and Canada since the 1930's. Your risks are similar to those of any testosterone replacement buy may lower risk than alternative forms. During andropause, the risk of not receiving adequate hormone therapy can outweigh the risks of replacing testosterone.

Risks of not receiving testosterone therapy after andropause include but are not limited to:
Arteriosclerosis, elevation of cholesterol, obesity, loss of strength and stamina, generalized aging, osteoporosis, mood disorders, depression, arthritis, loss of libido, erectile dysfunction, loss of skin tone, diabetes, increased over all inflammatory processes, dementia and Alzheimer's disease, and many other symptoms of aging.

CONSENT FOR TREATMENT: I consent to the insertion of testosterone pellets in my hip. I have been informed that I may experience any of the complications to this procedure as described below. **Surgical risks are the same as for any minor medical procedure.**

Side effects may include:
Bleeding, bruising, swelling, infection and pain. Lack of effect (typically from lack of absorption). Thinning hair, male pattern baldness. Increased growth of prostate and prostate tumors. Extrusion of pellets. Hyper sexuality (overactive libido). Ten to fifteen percent shrinkage in testicles size. There can also be a significant reduction in sperm production.

There is some risk, even with natural testosterone therapy, of enhancing an existing current prostate cancer to grow more rapidly. For this reason, a prostate specific antigen blood test is to be done before starting testosterone pellet therapy and will be conducted each year thereafter. If there is any question about possible prostate cancer, a follow-up with an ultrasound of the prostate gland may be required as well as a referral to a qualified specialist. While urinary symptoms typically improve with testosterone, rarely they may worsen, or worsen before improving. Testosterone therapy may increase one's hemoglobin and hematocrit or thicken one's blood. This problem can be diagnosed with a blood test. Thus, a complete blood count (Hemoglobin and Hematocrit.) should be done at least annually. This condition can be reversed simply by donating blood periodically.

BENEFITS OF TESTOSTERONE PELLETS INCLUDE:
Increased libido, energy, and sense of well-being. Increased muscle mass and strength and stamina. Decreased frequency and severity of migraine headaches. Decrease in mood swings, anxiety and irritability (secondary to hormonal decline). Decreased weight (Increase in lean body mass). Decrease in risk or severity of diabetes. Decreased risk of Alzheimer's and Dementia. Decreased risk of heart attack disease in men less than 75 years old with no pre-existing history of heart disease.

On January 31, 2014, the FDA issued a Drug and Safety Communication indicating that the FDA is investigating risks of heart attack and death in some men taking FDA approved testosterone products. The risks were found in men over the age of 65 years old with pre-existing heart disease and men over the age of 75 years old with or without pre-existing heart disease. These studies were performed with testosterone patches, testosterone creams and synthetic testosterone injections and did not include subcutaneous hormone pellet therapy.

I agree to immediately report to my practitioner's office any adverse reactions or problems that may be related to my therapy. Potential complications have been explained to me and I agree that I have received information regarding those risks, potential complications and benefits, and the nature of bio-identical and other treatments and have had all my questions answered. Furthermore, I have not been promised or guaranteed any specific benefits from the administration of bio-identical therapy. I certify this form has been fully explained to me, and I have read it or have had it read to me and I understand the contents. I accept these risks and benefits and I consent to the insertion of hormone pellets under my skin. This consent is ongoing for this and all future insertions.

I understand that payment is due in full at the time of service. I have been advised that most insurance companies do not consider pellet therapy to be a covered benefit.

_____ _____

Patient Print Name Patient Signature

_____ _____

Patient Date of Birth Date

WHAT MIGHT OCCUR AFTER A PELLEET 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.

FLUID RETENTION: Testosterone stimulates the muscle to grow and retain water which may result in a weight change of two to five pounds. This is only temporary. This happens frequently with the first insertion, and especially during hot, humid weather conditions.

SWELLING of the HANDS & FEET: This is common in hot and humid weather. It may be treated by drinking lots of water, reducing your salt intake, taking cider vinegar capsules daily, (found at most health and food stores) or by taking a mild diuretic, which the office can prescribe.

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

FACIAL BREAKOUTS: Some pimples may arise if the body is very deficient in testosterone. This lasts a short period of time and can handled with a good face cleanings routine, astringents and toner. If these solutions do not help, please call the office for suggestions and possibly prescriptions.

HAIR LOSS: Is rare and usually occurs in patients who convert testosterone to DHT. Dosage adjustment generally reduces or eliminate the problem. Prescription medications may be necessary in rare cases.

_____	_____	_____
Print Name	Signature	Today's Date