Female New Patient Package

The contents of this package are your first step to restore your vitality.

Please take time to read this carefully and answer all the questions as completely as possible.

We look forward to partnering with you to help you feel your best again.

Thank you for your interest in BioTE Medical®. In order to determine if you are a candidate for bio- identical testosterone and estradiol pellets, we need laboratory and your history forms. We will evaluate your information prior to your consultation to determine if BioTE Medical® can help you live a healthier life. **If labs and paperwork are not completed and received at least 4 days prior to your consult, we will need to reschedule for a future date.**

Your blood work panel MUST include the following tests:

Estradiol
FSH
Testosterone Total
TSH
T4, Total
T3, Free
CBC
Complete Metabolic Panel
Vitamin D, 25-Hydroxy
Vitamin B12
Lipid Panel (Optional, $50 additional for self-pay, **must be a fasting blood draw to be accurate**)

Female Post Insertion Labs Needed at 5-6 weeks based on your practitioner's choice:

Testosterone Total
Estradiol
FSH

Important Note: If you are taking a pure Biotin supplement, please stop taking at least two weeks before you have any labs drawn.

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bioTE® MEDICAL

Female Patient Questionnaire & History

Name: _____ Today's Date: _____
(Last) (First) (Middle)

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

Home Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Work: _____ Other: _____

If we are unable to reach you, is it okay to leave a detailed message? ( ) Yes ( ) No

E-Mail Address: _____ **May we contact you via E-Mail?** ( ) YES ( ) NO

In Case of Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Primary Care Physician's Name: _____ Phone: _____

Preferred Pharmacy: _____

In the event we cannot contact you by the mean's you've provided above, do we have permission to speak to your emergency contact about your treatment? By initialing below you are giving us permission to speak with your emergency contact about your treatment. Client Initials: _____

Social:

( ) I am sexually active.
( ) I want to be sexually active.
( ) I have completed my family.
( ) My sex has suffered.
( ) I haven't been able to have an orgasm.

Habits:

( ) I use tobacco products.
( ) I drink alcoholic beverages _____ per week.
( ) I drink more than 10 alcoholic beverages a week.
( ) I use caffeine _____ a day.

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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: _____

Last menstrual period (estimate year if unknown): _____

How did you hear about this therapy?: _____

Preventative Medical Care:

( ) Medical/GYN Exam in the last year.
( ) Mammogram in the last 12 months.
( ) Bone Density in the last 12 months.
( ) Pelvic ultrasound in the last 12 months.

High Risk Past Medical/Surgical History:

( ) Breast Cancer.
( ) Uterine Cancer.
( ) Ovarian Cancer.
( ) Hysterectomy with removal of ovaries.
( ) Hysterectomy only.
( ) Oophorectomy Removal of Ovaries.

Birth Control Method:

( ) Menopause.
( ) Hysterectomy.
( ) Tubal Ligation.
( ) Birth Control Pills.
( ) Vasectomy.
( ) Other: _____

Medical Illnesses:

( ) High blood pressure.
( ) Heart bypass.
( ) High cholesterol.
( ) Hypertension.
( ) Heart Disease/Arrhythmia
( ) Stroke and/or heart attack.
( ) Blood clot and/or a pulmonary emboli.
( ) Seizure Disorder
( ) Any form of Hepatitis or HIV.
( ) Lupus or other auto immune disease.
( ) Fibromyalgia.
( ) Trouble passing urine or take Flomax or Avodart.
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis).
( ) Diabetes.
( ) Thyroid disease.
( ) Arthritis.
( ) Depression/anxiety.
( ) Psychiatric Disorder.
( ) Cancer (type): _____
Year: _____

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BHRT CHECKLIST FOR WOMEN

Symptom (please check mark):	Yes	No
Depressive mood		
Memory Loss		
Mental confusion		
Decreased sex drive/libido		
Sleep problems		
Mood changes/irritability		
Tension		
Migraine/severe headaches		
Difficulty to climax sexually		
Bloating		
Weight gain		
Breast tenderness		
Vaginal dryness		
Night sweats		
Hot Flashes		

Other symptoms that concern you:

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Hormone Replacement Fee Acknowledgment

Preventative medicine and bio-identical hormone replacement is a unique practice and is considered a form of alternative medicine. Although more insurance companies are reimbursing patients for BioTE® and other bio-identical hormone replacement therapies, there is no guarantee.

Canyon View Wellness & Spa, LLC is not contracted with any insurance companies, which means they are not obligated to pay for our services (blood work, consultations, insertions or pellets). We require payment at time of service and, if you choose, we will provide a form to send to your insurance company and a receipt showing that you paid out of pocket. WE WILL NOT, however, communicate in any way with insurance companies. If you as the patient want to go through your insurance for lab work, you are responsible for any fees associated with lab work not covered by your insurance and you must obtain authorization from your insurance company to verify if your lab work is covered.

The form and receipt are your responsibility and serve as evidence of your treatment. We will not call, write, pre-certify, or make any contact with your insurance company. Any follow up letters from your insurance to us will be thrown away. If we receive a check from your insurance company, we will not cash it, but instead 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. This is the best idea for those patients who have an HSA as an option in their medical coverage.

Self-Pay Lab Work (Includes Consult) ……. $350.00

Consult Only Fee ……. $200.00

Female Hormone Pellet Insertion Fee …… $325.00

Self-Pay Female Annual Lab Work…….. $120.00

Cancellation within 24 hours or No Show Fee ……..$75.00

Returned Check Fee……$25.00

We accept the following forms of payment:

Master Card, Visa, Discover, American Express, Personal Checks and Cash.

Print Name _____ **Signature** _____ **Today's Date** _____

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HIPAA Information and Consent Form

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.

Signature of Patient: _____

I understand that this consent shall remain in force from this time forward.

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