HEALTH HISTORY QUESTIONNAIRE

Your honest replies to the questions within this questionnaire will assist Dr. Ruterbusch in developing a comprehensive and appropriate treatment plan for you. All answers and information contained in this questionnaire will be kept confidential.

Name *(Last, First, M.I.):* ☐ M ☐ F					**DOB:**	
Marital status:	☐ Single	☐ Partnered	☐ Married	☐ Separated	☐ Divorced	☐ Widowed
Age:			**Height:**		**Weight:**	
Address:			**City:**		**State:**	**Zip:**
Email address:			**Phone Number:**			Cell or Home?
Primary Care or referring doctor:			**Date of last physical exam:**			

PERSONAL HEALTH HISTORY

Please describe your goals, area(s) of concern, and issues that you would like addressed:

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Please List ALL current or past hormone replacement or testosterone therapy medically supervised or otherwise

Name the Drug	Date Prescribed	Strength	Frequency Taken

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No

Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
	Have you been diagnosed with HIV? If yes, date of diagnosis_____	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

Please explain any "yes" answers: _____

WOMEN ONLY- PLEASE EXPLAIN ANY "YES" ANSWERS BELOW

Age at onset of menstruation:		
Date of last menstruation:		
Period every_____days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No

Number of pregnancies_____Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you experience vaginal dryness/painful intercourse?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and mammogram exam?		
Name/Contact information of your OB/GYN:		

MEN ONLY- PLEASE EXPLAIN ANY "YES" ANSWERS BELOW

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No
Name/Contact information of Urologist (if applicable):		

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

Please explain any "yes" answers referenced above:

Hormone Deficiency Questionnaire

Sign and Symptom	Never	Sometimes	Often	Sign and Symptom	Never	Sometimes	Often
Low Mood/Depression				Decrease in lean muscle			
Irritability				Muscle Soreness/Weakness			
Anxiety				Body/Joint Aches			
Anger/Aggression				Decrease in strength/Stamina			
Discouragement/Pessimism				Elevated Blood Pressure			
Decreased interest in activities/relationships				Digestive Problems			
Decreased productivity at work				Low blood Sugar/hypoglycemia			
Decreased initiative/motivation/drive				Sweet/Carb Cravings			
Concentration Problems				Caffeine/Stimulant Cravings			
Memory problems					**Mild**	**Moderate**	**Severe**
Foggy Thinking				Increased fat on hips/breast/thighs			
Lower Libido				Weight Loss			
Erectile Dysfunction				Weight Gain			
Decreased Morning Erections				Body/Head Hair Loss			
Increased Fatigue				Dry Skin/ Thinning Skin			

Please indicate services you are interested in:

- ☐ Testosterone Replacement Therapy
- ☐ Bio-identical Hormone Therapy
- ☐ Growth Hormone Restoration
- ☐ Medical Weight Control
- ☐ Cosmetic/Skincare
- ☐ Nutritional Supplements
- ☐ IV infusion
- ☐ Discounted Lab work

Please sign and date below, indicating that you have answered the questions accurately and to the best of your ability.

_____
Patients Name (Printed)

_____ _____
Patients Signature Date

Kick Some Mass Clinical Procedures

PATIENT CONSENT TO HORMONE RESTORATION, WEIGHT LOSS AND NUTRITIONAL THERAPY

Please initial, indicating you understand and agree with the following statements. Then sign below. If you have any questions, please discuss the same with Dr. Jeffrey Ruterbusch before signing below. If under the age of 21 a parent or guardian must also sign.

_____The number of patients we see is limited by appointment only. Missed appointments cause additional expense and inconvenience to other patients. Please notify us twenty-four (24) hours in advance if you are unable to keep your appointment. **BHRT patients may be subject to $75 administrative fee for missed appointments in which Kick Some Mass is not notified in advance.**

_____Most health insurance companies (Campus, Blue Cross, Medicare, and Medicaid) typically **do not** provide coverage for medically monitored weight-loss and Bio-Identical Hormone Restoration Therapy (BHRT). **Therefore, we do not take any form of payment from third party companies and all services must be paid for at the time services are rendered by cash, check, or credit card.**

___ I understand that if I choose to file a claim with a third-party insurance, Kick Some Mass will provide receipts of transaction, but should not be expected to take further action.

_____If my treatment includes prescription medications (Hormones, Appetite Suppressants) I will carefully follow the instructions given, notify the doctor of any change in my medical history (especially heart or blood pressure problems) and not resell the medication nor will I share it with any friend or family member, EVER. I will not visit other doctors for the purpose of obtaining additional or duplicate medication of the same type.

_____I understand any treatments rendered through Kick Some Mass s are solely for the purpose of hormone balancing/restoration, body-fat reduction, and preventative medicine. We are not capable of serving as your primary care facility. If I become ill, I should contact my personal physician or visit an urgent care facility. If I become ill, I will discontinue any diet or weight-loss medication from this clinic until it is determined safe to resume the weight control program (Please call if uncertain).

_____I will consult my primary care physician and/or endocrinologist (medical physician) to encourage and facilitate physician communication with Dr. Ruterbusch regarding my treatments.

_____I understand that I will not be refunded for any lab orders or appointments once the service is provided, even if I do not qualify for any treatment.

_____I understand that I will only receive a prescription when medically necessary and that I do not automatically qualify for Testosterone Therapy upon my initial assessment. Obtaining a prescription is always at the physician's discretion and is determined based on medical assessment and a diagnosis.

_____I understand that I will not receive a refund for any medications once they are dispensed from the pharmacy. Once medications leave the pharmacy, they cannot be returned.

_ I have been advised and do understand all the risks and possible complications of BHRT, as well as noncompliance with Dr. Saya's recommended dosage. I further agree to administer all medications as directed by Dr. Ruterbusch.

_____I agree to immediately report to Dr. Ruterbusch any adverse reactions or problems, of whatever nature, whether said matters relate to BHRT treatment.

___I understand that restoring and balancing hormones accurately requires follow up blood work and monitoring. **These follow- ups may require additional costs for the patient. If I fail to submit to requested follow- ups I understand that my physician, at his/her discretion, will discontinue my therapy until requested information is received.**

___ I understand that if I am an out of state patient, I will provide current and updated Physical Exams every 6 months or as otherwise requested, to continue treatment.

_____ I understand that **NO PRESCRIPTION WILL BE PROVIDED UNLESS A CLINICAL NEED EXIST BASED ON REQUIRED LAB WORK, PHYSICIAN CONSULTATION, PHYSICAL EXAMINATION AND/OR CURRENT MEDICAL HISTORY. PLEASE NOTE, AGREEING TO LAB WORK AND PHYSICAL EXAM DOES NOT AUTOMATICALLY EQUATE TO CLINICAL NECESSITY AND A PRESCRIPTION**.

_____I hereby request and consent to the administration of BHRT and/or nutritional supplements by Dr. Ruterbusch for the purpose of restoring optimal levels, even where lab test results are within reference ranges for age and/or in circumstances where other medical organizations do not recommend the same.

MEN ONLY:

_____I do not hold Dr. Ruterbusch responsible for performing prostate cancer screening, PSA tests and/or rectal exams. I will consult with my primary care physician or urologist (medical physician) about them and provide all appropriate medical records and/or facilitate inter-physician communication regarding such evaluations. I understand a decision about treatment may depend on this information.

I have read, understand and agree to all the above statements.

Patient signature: _____

316 Parkridge Avenue Orange Park, FL 32065
PH: 813-445-7342 FX: 904-621-9300

Privacy Policy

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 1, 2022 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected heal thin formation that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information about you for treatment, payment, and health care operations. Following are examples of the types of uses and disclosures of yourprotected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that maybe made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your healthcare and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. Fore xample, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact us to request that these materials not be sent to you.

Uses and Disclosures Based on Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Marketing: We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information listed at the end of this notice.

Research; Death; Organ Donation: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law: We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your

protected health information to law enforcement officials.
Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Patient Rights
Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $25.00 for each page or$10.00 per hour to locate and copy your protected health information, and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities after April 1, 2022. After April1, 2022, the accounting will be provided for the past six (6) years. We will provide you with the date on which we made the disclosure, the name of the person or entity to which we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.
Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.
Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.
Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.
Questions and Complaints If you want more information about our privacy practices or have questions or concerns, please contact us using the information below. If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.We support your right to protect the privacy of your protected health information. We will not retaliate in anyway if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Name of Contact Person:

Ruth Ruterbusch

Office Manager
Kick Some Mass
Telephone: 904-589-0750
Address: 316 Parkridge Avenue, Orange Park, FL 32065

Please sign and date indicating you have read and understand you're Patient Rights.

Patient signature_____ Date:_____

Kick Some Mass – Jeffrey Ruterbusch D.O.
316 Parkridge Avenue
Orange Park, FL 32065
tel: (904) 589-0750
fax: (904) 621-9300

MEDICATION MANAGEMENT AGREEMENT

This agreement between_____(please print patients name) and Dr. Ruterbusch and Kick Some Mass Wellness, established guidelines and conditions required for the use of hormone replacement therapy (HRT) involving DEA controlled or scheduled medications. Dr. Ruterbusch and the patient agrees that these guidelines and conditions are an essential factor in maintaining a successful patient/practitioner relationship. Adverse side effects and/or physical/psychological dependence may develop after repeated use of these medications and therefore, are prescribed with caution.
The patient accepts and agrees to the following conditions:

1. I understand that the medication(s) I have purchased are prescribed for me based on diagnosis derived from my submitted medical history, lab work, and physical exam. They are to be based exclusively for treatment of these diagnoses.
2. I will immediately report any adverse side effects related to the use of my medication to Kick Some Mass and discontinue use until advised to resume usage.
3. I will safeguard my medications from loss or theft.
4. I will not share, sell or trade my medication for money, goods or services.
5. I agree that I will use my medication at the prescribed rate and dosage and will keep the medications in its respected labeled container.
6. I will not attempt to obtain scheduled HRT medications illegally or from any other health care practitioner without disclosing my current medication usage. I understand that it is against the law to do so.

Patient Signature: _____ Date: _____

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize Kick Some Mass Fax# 904-621-9300 to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information from (Dates):_____

☐ Other: _____

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION IS INDEFINITE.

Kick Some Mass

316 Parkridge Avenue
Orange Park, FL 32065

BHRT Informed Consent to Treat

The Nature of the Treatment

I hereby give my consent to evaluation and treatment by Kick Some Mass's staff, physician, Dr Jeffrey Ruterbusch, D.O., the following specified condition(s):

☐ Women: menopause or menopausal symptoms (including potential repletion of estrogen/estradiol, progesterone, DHEA, testosterone)

☐ Men: andropause or associated symptoms (including potential repletion of testosterone and DHEA, potential lowering of estrogen/estradiol levels)

☐ Men/Women: other hormone imbalances (please specify) - Thyroid abnormalities, Growth hormone abnormalities including decreased or suboptimal IGF -1 , decreased or suboptimal Vitamin D-3 levels.

☐ Men/Women: other (please specify) – Nutritional deficiencies (vitamins, minerals, amino acids, etc) – may include IV infusion supplementation, Overweight/Obesity (may include medically supervised weight loss with appetite suppressants – phentermine -, injectables (Lipo-C), etc.

☐ Men/Women: other (please specify) –

_____

_____

_____

I agree to the administration of hormone replacement therapy and/or nutritional supplements, including vitamins, minerals and anti-oxidants and/or drugs designed to alter hormone levels, all as appropriate to my specific diagnosis, particular condition and treatment objectives.

Alternative Treatment Methods and Their General Nature

The reasonable alternatives to this treatment have been explained to me and they include:

1. Leaving the hormone levels as they are.
2. Treating age related diseases as they appear.
3. Using pharmaceutical agents that are not bioidentical in nature (synthetics)

☐ I understand the foregoing alternatives and am choosing to consent to the treatment plan prepared for me by Kick Some Mass to address the condition(s) indicated above.

The General Nature and Extent of Treatment- Related Risks

Women: ☐ I understand that the possible side effects for women on estrogen, progesterone and/or testosterone may include breast swelling and/or discomfort, fluid retention, dizziness, thickening of the lining of the uterus (break-through bleeding), acne, unwanted hair growth, headaches, slight deepening of the voice, slight enlargement of the clitoris, potential increased risk of blood clots, and worsening of (1) ovarian cysts, (2) uterine fibroids, (3) endometriosis, and (4) fibrocystic disease. Many of these effects can be temporary as your body adjusts to restoration. Some of these potential side effects can often be addressed by adjusting hormone levels or prescribing simple remedies. I also

understand that if topical hormone replacement treatment (cream, gel, etc.) is prescribed for me that I should take extreme care to avoid any collateral exposure via direct skin-to-skin contact with the application site or exposure to contaminated bed linens, clothes, etc. for any children, pets, co-habitants of the home, or anyone else whom may come into contact with the hormonal treatment cream/gel. I have been informed that accidental collateral exposure may significantly impact the hormone levels of those affected.

Men: ☐ understand that the possible side effects for men on testosterone replacement are acne, persistent erections, unwanted hair growth/loss, enlargement of the prostate, enlargement of breast tissue (we will monitor and treat estrogen levels), minor testicular atrophy, salt retention, increase in blood pressure, decreased sperm count, an increase in the number of red blood cells (erythrocytosis) with corresponding increase in hematocrit and/or hemoglobin (your blood will be monitored for this). Many of these effects can be temporary as your body adjusts to restoration. Some of these potential side effects can often be addressed by adjusting hormone levels or prescribing simple remedies. I also understand that if topical hormone replacement treatment (cream, gel, etc) is prescribed for me that I should take extreme care to avoid any collateral exposure via direct skin-to-skin contact with the application site or exposure to contaminated bed linens, clothes, etc. for any children, pets, co-habitants of the home, or anyone else whom may come into contact with the hormonal treatment cream/gel. I have been informed that accidental collateral exposure may significantly impact the hormone levels of those affected.

Safety of Hormone Replacement

Although, in my physician's opinion, the majority of data points toward safety, there remains controversy regarding the correlation between the use of bioidentical hormone therapy and cancer. Recent data demonstrates that natural progesterone and estriol/estradiol may be protective against breast cancer.

I understand that careful surveillance and close monitoring are requirements of all patients to minimize any possible risk. I understand that Kick Some Mass will monitor my hormone levels and various other laboratory values as they pertain to my treatment goals. However, I also understand that an integral part of health maintenance is obtaining and remaining up to date with age-appropriate screening tests aimed at early detection of life-threatening diseases.

☐Male patients: I, _____, agree to obtain and remain up to date on all age-appropriate screenings including, but not limited to, colonoscopy, PSA and DRE (digital rectal exam), cardiac screenings as necessary (stress test, etc.). I agree to obtain these screenings through the appropriate physician(s) (PCP, cardiologist, urologist, etc) and will not hold Kick Some Mass's staff, physician Jeffrey Ruterbusch, D.O., or healthcare practitioners responsible or liable for performing these screenings or treating/managing any abnormal findings relating to these screenings. I acknowledge that Kick Some Mass would like to be supplied with copies of my most current and any future screening results and that, if I do not have them at my initial visit, *by signing this consent* I express my desire to initiate my treatment and give permission to Kick Some Mass and physician, Jeffrey Ruterbusch D.O., to commence treatment without first knowing the results of or reviewing said screenings. In doing so, I

release Kick Some Mass and physician, Jeffrey Ruterbusch D.O. of any claims of liability for prostate cancer, breast cancer, testicular cancer, and/or colon cancer. Further, I agree to immediately notify Kick Some Massand physician, Jeffrey Ruterbusch D.O., of any abnormal findings on above-noted screenings and supply a copy of any applicable records for their review.

☐Female patients: I,_____, agree to obtain and remain up to date on all age-appropriate screenings including, but not limited to, colonoscopy, PAP smear and pelvic exam, Mammogram and breast exam, DEXA scan, and cardiac screenings as necessary (stress test, etc.). I agree to obtain these screenings through the appropriate physician(s) (PCP, OBGYN, cardiologist, etc) and will not hold Kick Some Mass's staff, physician Jeffrey Ruterbusch D.O., or healthcare practitioners responsible or liable for performing these screenings or treating/managing any abnormal findings relating to these screenings. I acknowledge that Kick Some Mass would like to be supplied with copies of my most current and any future screening results and that, if I do not have them at my initial visit, *by signing this consent* I express my desire to initiate my treatment at Kick Some Mass and give permission to Kick Some Mass and physician, Jeffrey Ruterbusch D.O., to commence treatment without first knowing the results of or reviewing said screenings. In doing so, I release Kick Some Mas and physician, Jeffrey Ruterbusch D.O. of any claims of liability for breast cancer, cervical cancer, ovarian cancer, uterine cancer, and/or colon cancer. Further, I agree to immediately notify Kick Some Mass and physician, Jeffrey Ruterbusch D.O, of any abnormal findings on above-noted screenings and supply a copy of any applicable records for their review.

☐Female patients **(IF APPLICABLE)**:

I,_____, understand that it has been **more than one year** since my last mammogram.

The health professionals at Kick Some Mass strongly recommend annual mammograms because we consider these vital in the early detection of breast cancer.

I agree and understand that it is not the responsibility of Kick Some Mass or physician, Jeffrey Ruterbusch D.O., to perform my recommended Mammogram screening and breast exam.

I also understand that certain types of breast cancer, **once present**, may be stimulated by estrogen including my own body's estrogen, and taking estrogen therapy with a **present/active** breast cancer may worsen the chances of survival.

I also understand there are possible benefits associated with this therapy but that no guarantee has been made to me regarding outcomes of this treatment. I also understand that the benefits derived from antioxidant therapy and vitamin therapy will cease and those derived from hormone therapy and drugs that alter hormone levels will reverse if the therapy is discontinued.

I also understand that if I am female and become pregnant, I should stop the entire treatment protocol immediately and notify my physician (see separate disclaimer and warning). I understand that this hormone therapy is not for the purpose of preventing pregnancy, and that if I become pregnant on this therapy it could present risk to the fetus (unborn child).

My Obligations and Representations

Any questions I have regarding this treatment have been answered to my satisfaction. I understand that I will be

responsible for administering the hormones prescribed to me. I will comply with the recommended dose and methods of administration. I also agree to participate in the initial and subsequent hormone testing, as required to safely monitor and treat my hormone levels.

I certify that I am under the regular care of another physician (Primary Care Physician, OBGYN, Urologist, etc.) for all other medical conditions. I will consult my physician(s) for any other medical services I may require. I understand that this is a specialized practice. I also understand that I will continue under the care of my other physician(s) for any on-going medical condition as well as for any medical consultation that I may need.

Being aware of all aforementioned facts and notices in this document, and after weighing potential risks vs potential benefits, I elect to commence the aforesaid treatment at Kick Some Mass with physician, Jeffrey Ruterbusch D.O., and assume full liability for any adverse effects that may result from the proposed treatment. I waive any claim in law or equity for redress of any grievance that I may have concerning or resulting from the therapy, except as that claim pertains to grossly negligent administration of the therapy.

I fully understand the nature and purpose of portions of the aforementioned treatment may be considered experimental because of the lack of adequate scientific evidence or peer-reviewed publications supporting the underlying premise of bioidentical hormone replacement therapy and that such therapy might even be considered by some medical professionals to be medically unnecessary because it is not aimed at treating a particular disease.

I understand that I may suspend or terminate treatment at any time and hereby agree to immediately notify the physician of any desire to suspend or terminate this treatment so that such suspension or termination may be done safely.

Consent

I hereby authorize my physician to evaluate and treat the conditions I specified on the above pages (this is a 4-page document). I understand my physician may be assisted by other health professionals, as necessary, and agree to their participation in my care as it relates to the evaluation and treatment of the conditions this Consent to Treat covers. I certify that I am 18 years of age or older, am competent to sign this Consent to Treat, and have done so of my own free will.

_____
Patient Name (please print)

_____
Signature of Patient

_____
Kick Some Mass Signature
(Staff/Physician/Healthcare Practitioner)

_____
Date

Kick Some Mass
316 Parkridge Avenue
Orange Park, FL 32065

Kick Some Mass CONSENT AND AUTHORIZATION FOR ELECTRONIC COMMUNICATION (E-MAIL)

E-mail communication provides for a fast and easy way to communicate with your healthcare provider for those issues that are non-emergent, non-urgent or non-critical. It is not a replacement for the interpersonal contact that is the very basis of the patient-healthcare provider relationship; rather it can support and strengthen an already established relationship.

The following summarizes the information you need to determine whether you wish to supplement your healthcare experience at our practice by electronically communicating with staff members.

General Considerations

- E-mail communication will be considered and treated with the same degree of privacy and confidentiality as written medical records.
- Standard e-mail services, such as Gmail, AOL, Yahoo, and Hotmail are not secure. This means that the e-mail messages are not encrypted and can be intercepted and read by unauthorized individuals.
- Transmitting e-mail that contains protected health information through an e-mail system that is not encrypted does not meet the security guidelines as required by the Health Information Protection and Accountability Act (HIPAA).
- Your E-mail address will not be used for external marketing purposes without your permission. You may receive a group mailing from the practice; however, the recipients e-mail addresses will be hidden.

Provider Responsibilities

- The Provider will attempt to electronically confirm your e-mail address by requesting a return response to all e-mail messages.
- Your provider may route your e-mail messages to other members of the staff for informational purposes or for expediting a response.
- Designated staff may receive and read your e-mail.
- The provider will make every attempt to respond to your email message within 1 business days. If you do not receive a response from the provider within 1 business days, please contact the office.
- Copies of e-mails sent and received from and to you will be incorporated into your medical record. You are advised to retain all electronic correspondence for your own files.

Patient Responsibilities

- E-mail messages should not be used for emergencies or time sensitive situations. In event of a medical emergency, you should contact 911. For emergent or time sensitive situations, you should contact your healthcare provider through the office.
- E-mail messages should be concise. Please arrange for an office appointment if the issue is too complex or sensitive to discuss via e-mail.
- Please key in your full name and the topic, i.e., medication question, in the subject line. This will serve to identify you as the sender of the e-mail.
- Please acknowledge that you received and read the provider's message by return e-mail to the provider

ADDING DEFY MEDICAL TO YOUR APPROVED SENDERS LIST

Due to the importance of using email we want to make sure that every patient who provides us their email address is able to receive our communication. In order to protect your privacy many email providers have strict rules which filter any incoming emails containing large attachments or specific content. Health information such as blood test results are sent by email in an attachment which can be blocked by your email provider's security filter which is designed to protect you from receiving anything which might harm your computer. Unfortunately, this security feature can also block legitimate emails unless the senders address is approved by the recipient**. If you would like to use email as a means of communication, please be sure to unblock emails from defymedical.com. Depending on your email service provider, there are ways to unblock email addresses and approve the sender so that you may receive emails. Also be sure to check your SPAM or junk email inboxes for emails sent by Kick Some Mass**.

CONSENT AND AUTHORIZATION FOR ELECTRONIC COMMUNICATION (E-MAIL)

I have read and understood the above description of the risks and responsibilities associated with electronic communication with my healthcare provider.

I acknowledge that commonly used e-mail services are not secure and fall outside of the security requirements set forth by the Health Insurance Portability and Accountability Act for the transmission of protected health information.

I have been given the opportunity to discuss electronic communication with my healthcare provider and have had all my questions answered.

In consideration of my desire to use electronic communication as supplement to in-person office visits with my provider, I hereby consent to electronic communication via non-secure e-mail services.

I understand that I may revoke my consent to communicate electronically at any time by notifying Defy Medical in writing, but if I do, the revocation will not have any effect on actions my healthcare provider has already taken in reliance on my consent.

I agree to release my provider and the practice from any and all liability that may occur due to electronic communication over a non-secure network.

I further agree to be held accountable for the patient responsibilities as outlined above.

PATIENT

_____

Patient Authorized E-mail Address

_____

Patient Signature

_____

Date

_____

Kick Some Mass

316 Parkridge Avenue
Orange Park, FL 32065

BHRT and Pregnancy Disclaimer, Warning, and Patient Agreement (Premenopausal Women)

I understand that testosterone replacement therapy is not to be used by female patients who are pregnant or trying to become pregnant. I have been counseled on the potential risks of using testosterone replacement therapy during pregnancy, particularly the fact that testosterone usage in pregnant women has sometimes been shown to partially masculinize the external genitalia of a developing female fetus (potentially resulting in an enlarged clitoris, ambiguous genitalia, etc). Furthermore, I understand that I should not be taking estrogen or progesterone supplementation while pregnant or trying to become pregnant. Pregnancy is a very intricate and delicate hormonal process and any exogenous hormones taken during pregnancy may have a detrimental effect on that process.

With these risks in mind, I agree to use a consistent and reliable form of contraception while on hormone replacement therapy to reduce the chances of pregnancy. Additionally, I agree to immediately notify Kick Some Mass's staff and physician, Dr Jeffrey Ruterbusch D.O., if at any time that I am taking BHRT: I decide to attempt to become pregnant, decide to discontinue contraception, or discover that I am pregnant so that they can quickly and safely discontinue my hormone replacement therapy.

I acknowledge understanding of the above-mentioned disclaimer/agreement and agree to release Kick Some Mass and associated physician, Jeffrey Ruterbusch D.O., and healthcare practitioners from any claims of liability for any potential adverse outcomes that may result from my failure to comply with this agreement.

Initial

- _____I truthfully state that I am not currently breastfeeding nor will breastfeed during administration of any prescribed medications or supplements. I understand that it is suggested that I not breastfeed after the last dose of medication/nutritional supplement is taken until I have consulted with Dr. Jeffrey Ruterbusch D.O.

- _____ If I decide to forgo the advice provided by the Kick Some Mass staff and breastfeed while administering any prescribed medications or supplements, I do not hold Kick Some Mass accountable for any harm caused to either myself or infant.

Print Name _____

Sign Name _____ Date _____