



## Philip Borgardt, M.D. Inc. New Patient Registration

**Please Print**

Today's Date									
PATIENT INFORMATION									
Full Legal Name (First) (Middle) (Last)						Email address			
Address (Number)		(Street)		(Apt. No.)		Home Phone			
City		State		Zip		Cell Phone		Cell Phone Provider	
Date of Birth		Age		Sex		Marital Status		Occupation	
Employer Name		Employer Street Address				City		State	Zip
Business Phone (Including Extension)									
Are you on Medicare?									
How Did You Hear About Us?									
SPOUSE'S INFORMATION									
Full Legal Name (First) (Middle) (Last)								Occupation	
Address (If Different From Above)		City			State	Zip	Home Phone		
Employer Name		Street Address		City	State	Zip	Business Phone (Ext)		
EMERGENCY INFORMATION									
Person to Notify in Case of Emergency						Relationship			
Address (Number)		(Street)		(Apt. No.)					
City					State	Zip	Home Phone		
INFORMATION FOR THE PATIENT									
1. Patients who carry standard health insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. All patients with standard health care insurance are expected to make payment as services are rendered, regardless of pending insurance, litigation, etc. 2. If you have any questions we will, of course, be happy to assist you.									

**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.  
**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.

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Signature:

Date:

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Print name:



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

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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)

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

Name of friend or family members (printed)

Relationship to patient

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

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

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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 \$220.00

### 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 - \$140.00
- Follow Up Phone Appointment - \$ 150.00
- Combined Hormone/Weight Loss Appointment- \$ 150.00
- Phone Combo Appointment - \$160.00

### 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 - \$180.00

***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 \$40.00 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.

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Patient Name – Please Print

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Date

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Patient Signature

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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: \_\_\_\_\_

\_\_\_\_\_

<b>Have you had (circle):</b>	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? \_\_\_\_\_

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### **Personal History**

- |  |  |
|--|--|
| <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> Endometriosis       |
| <input type="checkbox"/> Fibrocystic Disease     | <input type="checkbox"/> Cancer (type) _____ |
| <input type="checkbox"/> Fibroids                | <input type="checkbox"/> Osteoporosis        |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Stroke                  | <input type="checkbox"/> Thrombophlebitis    |
| <input type="checkbox"/> Impaired Liver Function |  |

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               |



## Philip Borgardt, M.D. Inc.

### Periods:

- ☐ None ☐ Regular \_\_\_\_\_  
☐ Irregular \_\_\_\_\_ Explain (heavy, how long, etc) \_\_\_\_\_

### Surgery:

#### Date of Surgery:

- ☐ Oophorectomy \_\_\_\_\_ (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 \_\_\_\_\_