MALE New Patient Package

ReGenesis

"A Center for Vitality and Wellness"
176 Fairway Dr Kerrville, TX 78028 Phone: (830) 792-0805

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.

Thank you for your interest in BioTE Medical®. In order to determine if you are a candidate for bio-identical testosterone pellets, we need laboratory and your history forms. We will evaluate your information prior to your consultation to determine if you are in need of balancing your hormones. We will then be able to schedule an appointment for the insertion of the pellet.

Please be aware that insurance will not cover the cost of the pellet therapy, and the price is:

Male Hormone Pellets and Insertion Fee……$585.00, $700.00 ($750.00 if >2000 mg)

Have your blood drawn at any Quest Diagnostics or CPL Laboratory. We prefer the use of Quest Diagnostics because they have the most accurate hormone panels. We have Quest available in our office for your convenience. If you are not insured or have a high deductible, talk to your doctor about self-pay pricing on your labs. We request the tests listed below and have a phlebotomist here on site to help you. 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 up to two weeks for your lab results to be received by our office.**

Your blood work panel MUST include the following tests:

- Estradiol
- PSA Total
- Testosterone, Total and Free
- TSH (Thyroid Stimulating Hormone)
- T4, Free
- T3, Free
- Prolactin
- CBC (Complete Blood Count)
- TPO (Thyroid Peroxidase Antibodies)
- CMP (Complete Metabolic Panel)
- Vitamin D, 25-Hydroxy
- Vitamin B12
- SHBG (Sex Hormone Binding Globulin)
- LH (Luteinizing Hormone)

(OFFICE PRICE/SELF PAY: $350.00)

Male Post Insertion Labs Needed at 4 Weeks after your first pellet:

- Estradiol
- CBC (Complete Blood Count)
- Testosterone, Total and Free
- SHBG (Sex Hormone Binding Globulin)
- TSH (Thyroid Stimulating Hormone)
- T3, Free
- T4, Free

(OFFICE PRICE/SELF PAY: $100.00-$150.00)

ReGenesis: A Center for Vitality and Wellness

Insurance Disclaimer

ReGenesis – A Center for Vitality and Wellness is **NOT** contracted nor associated with any insurance companies, with means, insurance companies are not obligated to pay for our services (cosmetic injections, insertions of hormone pellets, or the pellet itself.) We require payment at time of service. Upon patient request, ReGenesis will provide a form for you to send to your insurance company and a receipt showing that you paid out of pocket.

The form and receipt are your responsibility and serve as your evidence of treatment. We will **NOT** call, write, pre-certify, or make any contact with your insurance company. If ReGenesis receives any follow-up letters from your insurance company, they will be shredded. Any telephone calls from an insurance company in regard to the above mentioned treatment will not be returned. If we receive a check from your insurance company, we will not cash it but return it to the sender.

For patients with a Health Savings Account (HSA), you may use this to pay for your treatment if your HSA allows you to do so. Determining HSA benefits is the sole responsibility of the patient.

_____ _____ _____

Print Name Signature Today's Date

Male Patient Questionnaire & History

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

Date of Birth: _____ Age: _____ Occupation: _____

Home Address: _____

City: _____ State:_____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

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:_____

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

In the event we cannot contact you by the mean's you have 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.
( ) My sex has suffered.
( ) I have used steroids in the past for athletic purposes.

Habits:

( ) I smoke cigarettes or cigars_____per day.
( ) I drink alcoholic beverages _____per week.
( ) I drink more than 10 alcoholic beverages a week.
( ) I use caffeine_____a day.

Male Patient Medical History

Any known drug allergies: _____ Estimated Weight: _____

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
( ) Heart bypass
( ) High cholesterol
( ) Hypertension
( ) Heart disease
( ) Stroke and/or heart attack
( ) Blood clot and/or a pulmonary emboli
( ) Hemochromatosis
( ) Diabetes
( ) Other: _____

( ) Trouble passing urine or take Flomax or Avodart
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis)
( ) Elevated PSA
( ) Testicular of Prostate Cancer
( ) Depression/anxiety
( ) Psychiatric disorder
( ) Thyroid disease
( ) Arthritis
( ) Cancer (type and year): _____

I understand that if I begin testosterone replacement with any testosterone treatment, including testosterone pellets, that I will produce less testosterone from my testicles and if I stope 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 Signature Today's Date

BHRT Checklist for Men

Name: _____ Date: _____

Email: _____

Symptom (please check all that apply)	Never	Mild	Moderate	Severe
Decline in general well being (general state of health)				
Joint pain/muscle ache (lower back/joint/limb pain)				
Excessive sweating (sudden episodes/hot flashes)				
Sleep problems (difficulty falling/staying asleep/wake up tired)				
Increased need for sleep (feeling tired often)				
Irritability (aggressive/easily upset/moody)				
Nervousness (inner tension/restlessness				
Anxiety (feeling panicky)				
Depressed mood (feeling down/sad/lack of drive/useless)				
Exhaustion/lacking vitality (decreased performance & activity/lack of interest/motivation				
Declining mental ability/focus/concentration				
Feeling you have past 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				
Decrease in beard growth				
New migraine headaches				
Decreased desire/libido				
Decreased morning erections				
Decreased ability to perform sexually				
Infrequent or absent ejaculations				
No results from ED medications				

Other: _____

Hormone Replacement Fee Acknowledgment for Males

Preventative medicine and bio-identical hormone replacement is a unique practice and is considered a form of alternative medicine. Even though Dr. Kerri Truelock is a board-certified OB/GYN physician, insurance companies do not recognize bio-identical hormone replacement therapy as a necessary medicine. It is considered aesthetic medicine (similar to plastic surgery) and therefore, is not covered by health insurance companies in most cases.

During your initial ReGenesis hormone consult, you will discuss all options of hormone therapy. This will not be filed with your insurance company. If you choose pellet therapy, you are acknowledging that ReGenesis is a distinct and separate entity with no relationship to any insurance companies. You are ultimately responsible for all professional fees. Talk with your doctor more about information that may help you with covering the costs of your labs.

Payment is due at time of service for the following:

Laboratory Fees – Initial labs:_____ $350.00
Laboratory Fees – 4 week follow up labs: _____ $100.00-$150.00
New Male Patient Consult Fee: _____ $150.00
Male Pellet Therapy plus Insertion Fee: _____$585.00, $700.00 ($750.00 if > 2000 mg)

We accept the following forms of payment:

Master Card * Visa * Discover * American Express * Personal Checks * Cash

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

Commonly Asked Questions

Q. What is BioTE®?
A. BioTE® is a Bio-Identical form of hormone therapy that seeks to return the hormone to youthful levels in men and women.

Q. How do I know if I'm a candidate for pellets?
A. Symptoms may vary widely from depression and anxiety to night sweats and sleeplessness for example. You will be given a lab slip to have blood work done which will determine your hormone levels. Once the doctor reviews and determines you are a candidate, we will schedule an appointment for insertion.

Q. Do I have blood work done before each treatment?
A. No, only initially and 4-8 weeks later to set your dosing. You may have it done again if there are significant changes.

Q. What are the pellets made from?
A. They are made from wild yams and soy. Wild yams and soy have the highest concentration of hormones of any substance. There are no known allergens associated with wild yams and soy, because once the hormone is made it is no longer yam or soy.

Q. How long will the treatment last?
A. Every 3-6 months depending on the person. Everyone is different so it depends on how you feel and what the doctor determines is right for you. If you are really active, you are under a lot of stress or it is extremely hot, your treatment may not last as long. Absorption rate is based on cardiac output.

Q. Is the therapy FDA approved?
A. What the pellets are made of is FDA approved and regulated, the process of making pellets is regulated by the State Pharmacy Board, and the distribution is regulated by the DEA and Respective State Pharmacy Boards. The PROCEDURE of placing pellets is NOT an FDA approved procedure. The pellets are derived from wild yams and soy and are all natural and bio-identical. Meaning they are the exact replication of what the body makes.

Q. How are they administered?
A. Your practitioner will implant the pellets in the fat under the skin of the hip. A small incision is made in the hip. The pellets are inserted. No stitch is required.

Q. Does it matter if I am on birth control? (Females Only)
A. No, the doctor can determine what your hormone needs are even if you are on birth control.

Q. Are there any side effects?
A. The majority of side effects are temporary and typically only happens on the first dose. All are very treatable. There are no serious side effects.

Q. What if I am already on HRT of some sort like creams, patches, pills?
A. This is an easy transition. The doctor will be able to determine your needs even though you may be currently taking these other forms of HRT.

Q. What if I've had breast cancer?
A. Breast cancer survivors and/or those who have a history of breast cancer in their family may still be a candidate; however, this is to be determined by the physician. You should schedule a consultation with the doctor.

HIPPA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPPA) provides safeguards to protect your privacy. Implementation of HIPPA requirements officially began on April 14, 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 restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPPA 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 of 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 of 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 HIPPA.

4. You understand and agree to inspections of the office and review 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 both the practice and 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, _____ date_____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPPA INFORMATION FORM and any subsequent changes in the office policy. I understand that this consent shall remain in force this time forward.