Raymond S. Duong M.D., P.A.

Female New Patient Package

Welcome to Dr. Raymond Duong's office. Thank you for your interest in BioTe Medical.

Some benefits that BioTe can help with include:

Feel Younger and Happier

Regain Energy and Strength

Increase Mental Clarity

Decreased Joint and Muscle Pain

Increase Ability to Lose Weight

Restore or Increase Sex Drive

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

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

In order to determine if you are a candidate for bio- identical hormone pellets, we need laboratory results 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. Please complete the following tasks before your appointment:

To get a complete picture of how we can help you, Dr. Duong does require a copy of labs from the last 6 months, as well as your last history and physical from your current primary care physician. If you have had BioTe pellets before, we will also require a copy of those records.

We can not file the labs, consultation, nor BioTE pelleting to any insurance. This is an out of pocket expense. BioTE Medical does have reduced, negotiated rates with Quest which helps keep the cost of the labs down. Additional hormone labs will be required. We do need these labs to determine if you are a candidate. Your advanced hormone lab panels may take up to two weeks for your lab results to be received by our office. We will first schedule an office visit (consult) to review your medical history and symptom checklist, and of course address questions you may have about advanced hormone replacement pellet therapy and then have you do the lab work. We will have you go to a Quest lab for blood work. Then if you are a candidate and decide to move forward with BioTE therapy, we will schedule as appointment and preform the very simple procedure that takes a few minutes in our office.

Demographic

Name: _____ Today's Date: _____
(Last) (First)
Date of Birth: _____ Age: _____ Weight: _____ Height: _____

Occupation: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

E-Mail: _____ Do we have permission to leave a voice mail? Y N

Marital Status: ( ) Married ( ) Divorced ( ) Widow ( ) Living with partner ( ) Single

In Case of Emergency Contact: _____ Relationship: _____

Emergency Contact's Home Phone: _____Cell: _____

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

Address: _____
(City) (State) (Zip)

In the event we cannot you by the mean's you've 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 to your spouse or significant other about your treatment.

Spouse/Partner's Name: _____ Relationship: _____

_____
(Home Phone) (Cell Phone) (Work Phone)

Female Medical History

Name: _____ Date: _____

Any Known drug/environmental (i.e. tape/adhesive) allergies? ( ) Yes ( ) No

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

If yes, please explain: _____

Have you been on any hormone therapy in the past 6 months including but not limited to injections, gels, creams, patches, or pills? ( ) Yes ( ) No If so, what? _____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Nutritional/Vitamin Supplements:

_____

Current Medications: _____

_____

Surgeries, list all and when: _____

_____

Have you been seen by a gynecologist in the last year? ( ) Yes ( ) No

If so, did the gynecologist consider your health normal? ( ) Yes ( ) No

Other Pertinent Information: _____

Please mark any Medical Illnesses:

( ) High blood pressure
( ) High cholesterol
( ) Heart Disease
( ) Stroke and/or heart attack
( ) Hemochromatosis
( ) Depression/Anxiety
( ) Psychiatric Disorder
( ) Blood clot and/or pulmonary emboli
( ) Heart bypass
( ) Hypertension
( ) Arrhythmia
( ) Arthritis
( ) Diabetes
( ) Hashimoto's Thyroiditis
( ) Cancer, what type:_____
( ) Fibromyalgia

( ) Thyroid Disease, If so, what medication do you take _____

( ) Trouble passing urine or you take Flomax or Avodart

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

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Social History:

( ) 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. If so, how many per day? _____

( ) I drink alcoholic beverages. If so, how many per day? _____

( ) I drink more than 10 alcoholic beverages a week.

( ) I use caffeine

( ) I use recreational drugs

I understand that if I begin testosterone replacement with any testosterone treatment, including pellets, that I will produce less testosterone from my testicles and if I stop replacement therapy, 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)	(Date)

Female Hormone Replacement Fee Acknowledgement

You will be responsible for payment in full at the time of your appointment.

BioTe Medical Hormone Replacement Therapy is not covered by insurance nor do we file to insurance.

Consultation Fee	$150.00
Initial Lab Fee	$110.00
Female Hormone Pellet Insertion Fee	$400.00
Follow up Lab Fee- 6 weeks post insertion	Cost Varies
BioTe Supplements	Cost Varies

REQUEST TO RESTRICT DISCLOSURE TO HEALTH PLAN {Authorized by Section 13405(a) of the HITECH Act} I request that Raymond S. Duong M.D. not disclose my protected health information (PHI) to my health plan or other third party insurance carrier. Pursuant to Section 13405(a) of the HITECH Act, I understand I have the right to request restrictions on whether the Practice discloses my protected health information (PHI) with my health plan and the Practice is required to agree to my request unless the information is required to be disclosed to my health plan to comply with the law. The records of the restricted services/items for Biote Hormone Replacement Therapy will not be released or billed to my health plan or other third party insurance carrier for the purposes of payment or health care operations. I understand I am financially responsible for these Restricted Services/Items and will pay out-of-pocket, in full, at the time of service in order for the Practice to accept this restriction request.

We accept the following forms of payment:

Master Card, Visa, Discover, American Express

_____	_____	_____
Printed Name	Signature	Date

Female Testosterone and/or Estradiol Pellet Insertion Consent Form

Name: _____ Today's Date: _____

Pellets are bioidentical, structurally equivalent to the hormones your body naturally produces. Estrogen and testosterone are made in your ovaries and adrenal glands. Even prior to menopause, testosterone levels start to decrease. Bio-identical hormones have the same effects on your body as your own naturally occurring hormones did when you were producing them at adequate levels. Bio-identical hormone pellets are plant derived and are FDA monitored but not FDA approved for female hormone replacement. The pellet method of hormone replacement has been used in Europe and Canada for many years and by select practitioners in the United States.

Patients who are pre-menopausal are advised to **continue reliable birth control** while participating in pellet hormone replacement therapy. Testosterone is category X (could cause birth defects based on human/animal studies) and should not be given to pregnant women.

My birth control method is: (please circle) Abstinence, Birth control pill, Hysterectomy, IUD, Menopause, Tubal ligation, Vasectomy, Other

CONSENT FOR TREATMENT: I consent to the insertion of testosterone and/or estradiol pellets in my hip/abdomen. 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 and are included in the list of overall risks:** Bleeding, bruising, swelling, infection and pain; extrusion of pellets; hyper sexuality (overactive Libido); lack of effect (from lack of absorption); breast tenderness and swelling; increase in hair growth on the face; acne; water retention; increased growth of estrogen dependent tumors (endometrial cancer, breast cancer); birth defects in babies exposed to testosterone during their gestation; change in voice (which is reversible); clitoral enlargement (which is reversible). The estradiol dosage that I may receive can aggravate fibroids or polyps, if they exist, and can cause bleeding. Testosterone therapy may increase one's hemoglobin and hematocrit. This elevation can be seen with a blood test. Thus, a complete blood count 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. Decreased visceral fat. Decrease in risk or severity of diabetes. Decreased risk of heart disease. Decreased risk of Alzheimer's and dementia.

BENEFITS OF ESTRADIOL PELLETS INCLUDE: Decreased vaginal dryness. Increased skin elasticity. Decreased hot flashes, mood swings, depression, anxiety, and headaches caused by hormone fluctuations. Increase and maintenance of bone density. May prevent atherosclerosis (hardening and narrowing of the blood vessels) and complications associated with coronary artery disease. Decrease risk of Alzheimer's and dementia (neuroprotection).

I have read and understand the above. I have been encouraged and have had the opportunity to ask any questions regarding pellet therapy. All of my questions have been answered to my satisfaction. I further acknowledge that there may be risks of testosterone and or estrogen therapy that we do not yet know, at this time, and that the risks and benefits of this treatment have been explained to me and I have been informed that I may experience complications, including one or more of those listed above. 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 pellet insertions.** I understand that payment is due in full at the time of service. I have been advised that insurance companies do not consider pellet therapy to be a covered benefit. I acknowledge that my provider has no contracts with any insurance company and is not contractually obligated to pre-certify treatment with my insurance company or answer letters of appeal.

_____

Patient Signature

BHRT Checklist For Women

Name: _____ **Date:** _____

E-Mail: _____

Symptom (please check mark)	Never	Mild	Moderate	Severe
Depressive mood				
Fatigue				
Memory Loss				
Mental confusion				
Decreased sex drive/libido				
Sleep problems				
Mood changes/Irritability				
Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and Wrinkled Skin				
Hair is Falling Out				
Cold all the time				
Swelling all over the body				
Joint pain				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Breast Cancer		