YOU. DESIGNER HEALTH

8206 Vicksburg Ave. STE A | Lubbock, TX 79424
Phone: 806.401.0460 Fax: 855-490-4610
youdesignerhealth.com

NEW PATIENT PACKAGE

In order to determine if you are a candidate for bio-identical testosterone and/or estrogen pellets, we need lab work and your health history forms. We will evaluate your information prior to your consultation to determine if Hormone Pellet Therapy can help you live a healthier life. Please complete the following tasks before your appointment:

AT LEAST 1 WEEK BEFORE YOUR SCHEDULED CONSULTATION:

☐ Complete medical history form

☐ Complete lab work

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 a week for your lab results to be received by our office. If you are not insured or have a high deductible, call our office for self-pay lab work. Our preferred lab is CPL (Clinical Pathology Laboratories) 3724 20th St. Lubbock, Texas 79410. CPL is open M-F 7:30 - 5:00.

Your blood work panel MUST include the following tests:

Female

- ☐ Estradiol
- ☐ FSH
- ☐ Testosterone Total
- ☐ TSH
- ☐ T4, Total
- ☐ T3, Free
- ☐ T.P.O. Thyroid Peroxidase
- ☐ CBC
- ☐ Complete Metabolic Panel
- ☐ Vitamin D, 25-Hydroxy (Optional)
- ☐ Vitamin B12 (Optional)
- ☐ Lipid Panel (Optional) *(Must be a fasting blood draw to be accurate)*

Male

- ☐ Estradiol
- ☐ Testosterone Free & Total
- ☐ PSA Total
- ☐ TSH
- ☐ T4, Total
- ☐ T3, Free
- ☐ T.P.O. Thyroid Peroxidase
- ☐ CBC
- ☐ Complete Metabolic Panel
- ☐ Vitamin D, 25-Hydroxy
- ☐ Lipid Panel (Optional) (Must be a fasting blood draw to be accurate)

Post insertion labs needed 4-8 weeks after insertion based on your practitioner's choice:

Female

- ☐ FSH
- ☐ Testosterone Total
- ☐ CBC
- ☐ Estradiol
- ☐ Lipid Panel (Optional) *(Must be a fasting blood draw to be accurate)*
- ☐ TSH, T4 Total, T3 Free, TPO (Needed only if you've been prescribed thyroid medication

Male

- ☐ FSH
- ☐ Testosterone Free & Total
- ☐ PSA Total (If PSA was borderline on first insertion)
- ☐ CBC
- ☐ Lipid Panel (Optional) *(Must be a fasting blood draw to be accurate)*

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PATIENT QUESTIONNAIRE

Name: _____ Today's Date: _____
(LAST) (FIRST) (MIDDLE)

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

Address: _____
ADDRESS CITY STATE ZIP

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

In the event we cannot contact you by the means 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 with your spouse or significant other about your treatment.

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Any known drug allergies: _____

Have you ever had any issues with anesthesia?

☐ No ☐ Yes, please explain _____

Current Medications: _____

_____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Nutritional/Vitamin Supplements: _____

Surgeries, list all and when: _____

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MEDICAL HISTORY

Medical Illnesses

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

Social:

- ☐ I am sexually active
- ☐ I want to be sexually active
- ☐ I have completed my family
- ☐ My sex has suffered
- ☐ I haven't been able to have an orgasm
- ☐ I have used steroids for athletic purposes

Habits:

- ☐ I Smoke cigarettes/cigars _____ /day.
- ☐ I drink alcoholic beverages ____ / week.
- ☐ I drink 10+ alcoholic beverages/ week.
- ☐ I use caffeine _____ /day.

Female Patients

Preventative Medical Care:

- ☐ Last menstrual period (est. year if unknown): _____
- ☐ Last Pap: _____
  - ☐ Normal
  - ☐ Abnormal
- ☐ Last Mammogram:

  _____
  - ☐ Normal
  - ☐ Abnormal
- ☐ Medical/GYN Exam in the last 12 months
- ☐ Mammogram in the last 12 months
- ☐ Bone Density in the last 12 months
- ☐ Pelvic ultrasound in the last 12 months

Medical/Surgical History:

- ☐ Breast Cancer
- ☐ Uterine Cancer
- ☐ Ovarian Cancer
- ☐ Hysterectomy with removal of ovaries
- ☐ Hysterectomy only
- ☐ Oophorectomy Removal of Ovaries

Birth Control Method

- ☐ Menopause
- ☐ Hysterectomy
- ☐ Tubal Ligation
- ☐ Birth Control Pills
- ☐ Vasectomy
- ☐ Other: _____

  _____

  _____

Male Patients

- ☐ Testicular/Prostate Cancer
- ☐ Elevated PSA
- ☐ Prostate enlargement
- ☐ Prostate exam in the last 12 months

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HORMONE REPLACEMENT FEE ACKNOWLEDGMENT

Although more insurance companies are reimbursing patients for the Hormone Pellet Therapy, there is no guarantee. You will be responsible for payment in full at the time of your procedure.

We will give you paperwork to send to your insurance company to file for reimbursement upon request.

New Patient Consult Fee	$125
Female Hormone Pellet Insertion Fee	$350
Male Hormone Pellet Insertion Fee	$650
Male Pellet Insertion Fee (≥2000mg)	$750
Initial Labs	$195
Follow Up Labs	$95

We accept the following forms of payment:

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

PRINT NAME SIGNATURE TODAY'S DATE

J.Gorman

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SYMPTOM CHECKLIST

	Never	Mild	Moderate	Severe
Acne				
Decline in general well being				
Fatigue				
Joint pain/muscle ache				
Excessive sweating				
Sleep problems				
Increased need for sleep				
Irritability				
Nervousness				
Anxiety				
Depressed mood				
Exhaustion/lacking vitality				
Declining Mental Ability/Focus/Concentration				
Feeling you have passed your peak				
Feeling burned out/hit rock bottom				
Decreased muscle strength				
Weight Gain/Belly Fat/Inability to Lose Weight				
Rapid Hair Loss				
New Migraine Headaches				
Female				
Facial Hair				
Breast Tenderness				
Vaginal Dryness				
Hot Flashes				
Male				
Breast Development				
Shrinking Testicles				
Decrease in beard growth				
Decreased morning erections				
Decreased desire/libido				
Decreased ability to perform sexually				
Infrequent or Absent Ejaculations				
No Results from E.D. Medications				

Family History	No	Yes
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Breast Cancer		
Prostate Cancer		

Patient Name: _____

Date: _____

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TREATMENT PLAN

The following medications or supplements are recommended in addition to your pellet therapy. Please refer to the supplement brochure to help you understand why these are beneficial. Unless otherwise specified, these can be taken any time of day without regards to meals.

Supplements: These may be purchased in our office. When you run out they can be mailed to you for your convenience.

- ☐ **Probiotic** | _____
- ☐ **Omega 3** | _____
- ☐ **Iodine** | _____
- ☐ **DIM** | _____
- ☐ **Vitamin D3** | _____

Prescriptions: These have been called into your preferred pharmacy.

- ☐ **Progesterone/Prometrium** | Nightly:
- ☐ **Nature-Throid** _____ **mg** | Every morning Sample Given: ☐ Yes ☐ No
  This should be taken on an empty stomach. Please wait 30 minutes before putting anything else on your stomach. This includes coffee, food, medications, vitamins or supplements.
- ☐ Wean off **Synthroid/levothyroxine**
  Alternate your desiccated thyroid (Nature-throid) every other day with Synthroid/levothyroxine for 3 weeks then go to every day on your desiccated thyroid.
- ☐ **Femara** | 2.5 mg, ½ pill every 2 weeks
- ☐ Wean off your antidepressant (see wean protocol)
- ☐ **Spironolactone** | 100mg daily
- ☐ Other: _____

Please call or email for any questions about these recommendations.

I acknowledge that I have received a copy and understand the instructions on this form.

_____
Patient Initial

_____
Jennifer Gorman, MS, RD, LD

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WHAT MIGHT OCCUR AFTER A PELLET INSERTION

A significant hormonal transition will occur in the first four weeks after the insertion of your hormone pellets. Therefore, certain changes might develop that can be bothersome.

- ☐ **Fluid Retention:** Testosterone stimulates the muscle to grow and retain water, which may result in a weight change of two to five pounds. This is only temporary. This happens frequently with the first insertion, and especially during hot, humid weather conditions.
- ☐ **Swelling Of The Hands & Feet:** This is common in hot and humid weather. It may be treated by drinking lots of water, reducing your salt intake, taking cider vinegar capsules daily, (found at most health and food stores) or by taking a mild diuretic, which the office can prescribe.
- ☐ **Mood Swings/Irritability:** These may occur if you were quite deficient in hormones. They will disappear when enough hormones are in your system. 5HTP can be helpful for this temporary symptom and can be purchased at many health food stores.
- ☐ **Facial Breakout:** Some pimples may arise if the body is very deficient in testosterone. This lasts a short period of time and can be handled with a good face cleansing routine, astringents and toner. If these solutions do not help, please call the office for suggestions and possibly prescriptions.
- ☐ **Hair Loss:** This is rare and usually occurs in patients who convert testosterone to DHT. Dosage adjustment generally reduces or eliminates the problem. Prescription medications may be necessary in rare cases.
- ☐ **Hair Growth:** Testosterone may stimulate some growth of hair on your chin, chest, nipples and/or lower abdomen. This tends to be hereditary. You may also have to shave your legs and arms more often. Dosage adjustment generally reduces or eliminates the problem.
- ☐ **Uterine Spotting/Bleeding:** This may occur in the first few months after an insertion, especially if you have been prescribed progesterone and are not taking properly: i.e. missing doses, or not taking a high enough dose. Please notify the office if this occurs. Bleeding is not necessarily an indication of a significant uterine problem. More than likely, the uterus may be releasing tissue that needs to be eliminated. This tissue may have already been present in your uterus prior to getting pellets and is being released in response to the increase in hormones.

I acknowledge that I have received a copy and understand the instructions on this form.

_____
Patient Initial

_____
Jennifer Gorman, MS, RD, LD

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POST-INSERTION INSTRUCTIONS

A significant hormonal transition will occur in the first four weeks after the insertion of your hormone pellets. Therefore, certain changes might develop that can be bothersome.

- ☐ Your insertion site has been covered with two layers of bandages. Remove the outer pressure bandage any time after **3 days.** It must be removed as soon as it gets wet. The inner layer is either waterproof foam tape or steri-strips. They should be removed in **7 days.**
- ☐ We recommend putting an ice pack on the insertion area a couple of times for about 20 minutes each time over the next 4 to 5 hours. *Be sure to place something between the ice pack and your bandages/skin. Do not place ice packs directly on bare skin.*
- ☐ Do not take tub baths or get into a hot tub or swimming pool for **7 days.** You may shower but do not scrub the site until the incision is well healed (about 7 days).
- ☐ **No major exercises for the incision area for the next 7 days, this includes running, elliptical, squats, lunges, etc.**
- ☐ The sodium bicarbonate in the anesthetic may cause the site to swell for 1-3 days.
- ☐ The insertion site may be uncomfortable for up to 2 to 3 weeks. If there is itching or redness you may take 50 mg Benadryl for relief orally every 6 hours. Caution this can cause drowsiness!
- ☐ You may experience bruising, swelling, and/or redness of the insertion site which may last from a few days up to 2 to 3 weeks.
- ☐ You may notice some pinkish or bloody discoloration of the outer bandage. This is normal.
- ☐ If you experience bleeding from the incision, apply firm pressure for 5 minutes.
- ☐ Please call if you have any bleeding not relieved with pressure (not oozing), as this is NOT normal.
- ☐ Please call if you have any pus coming out of the insertion site, as this is NOT normal.

Reminders:

Remember to go for your post-insertion blood work 4-8 weeks after the insertion. Most men will need reinsertions of their pellets 5-6 months after their initial insertion. Most women will need re-insertions of their pellets 3-4 months after their initial insertion.

Please call as soon as symptoms that were relieved from the pellets start to return to make an appointment for a re-insertion. The charge for the second visit will only be for the insertion and not a consultation.

Additional Instructions: _____

_____

I acknowledge that I have received a copy and understand the instructions on this form.

_____
Patient Initial

_____
Jennifer Gorman, MS, RD, LD

FEMALE TESTOSTERONE AND/OR ESTRADIOL PELLET INSERTION CONSENT FORM

Bio-identical hormone pellets are concentrated hormones, biologically identical to the hormones you make in your own body prior to menopause. Estrogen and testosterone are made in your ovaries and adrenal gland prior to menopause. Bio-identical hormones have the same effects on your body as your own estrogen and testosterone.

Bio-identical hormone pellets are made from soy & yams and are FDA monitored but not approved for female hormonal replacement. The pellet method of hormone replacement has been used in Europe and Canada for many years and by select OB/GYNs and other specialists in the United States. You will have similar risks as you had prior to menopause, from the effects of estrogen and androgens, given as pellets.

Patients who are pre-menopausal are advised to continue reliable birth control while participating in pellet hormone replacement therapy. Testosterone is category X (will cause birth defects) and cannot 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. I have been informed that I may experience any of the complications to this procedure as described below. These side effects are similar to those related to traditional testosterone and/or estrogen replacement. **Surgical risks are the same as for any minor medical procedure and are included in the list of overall risks below:**

Bleeding, bruising, swelling, infection and pain; extrusion of pellets; hyper sexuality (overactive Libido); lack of effect (from lack of absorption); breast tenderness and swelling especially in the first three weeks (estrogen pellets only); increase in hair growth on the face, similar to pre-menopausal patterns; water retention (estrogen only); increased growth of estrogen dependent tumors (endometrial cancer, breast cancer); birth defects in babies exposed to testosterone during their gestation; growth of liver tumors, if already present; 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, or thicken one's blood. This problem can be diagnosed with a blood test. Thus, a complete blood count (Hemoglobin & Hematocrit) 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 weight. Decrease in risk or severity of diabetes. Decreased risk of heart disease. Decreased risk of Alzheimer's and dementia

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 agree to immediately report to my practitioner's office any adverse reactions or problems that may be related to my therapy. Potential complications have been explained to me and I agree that I have received information regarding those risks, potential complications and benefits, and the nature of bio-identical and other treatments and have had all my questions answered. Furthermore, I have not been promised or guaranteed any specific benefits from the administration of bio-identical therapy. I certify this form has been fully explained to me, and I have read it or have had it read to me and I understand its contents. 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 insertions.

I understand that payment is due in full at the time of service. I also understand that it is my responsibility to submit a claim to my insurance company for possible reimbursement. I have been advised that most insurance companies do not consider pellet therapy to be a covered benefit and my insurance company may not reimburse me, depending on my coverage. 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.

PRINT NAME SIGNATURE TODAY'S DATE

MALE TESTOSTERONE PELLET INSERTION CONSENT FORM

Bio-identical testosterone pellets are concentrated, compounded hormone, biologically identical to the testosterone that is made in your own body. Testosterone was made in your testicles prior to "andropause." Bio-identical hormones have the same effects on your body as your own testosterone Bio-identical hormone pellets are made from yams and bio-identical hormone replacement using pellets has been used in Europe, the U.S. and Canada since the 1930's. Your risks are similar to those of any testosterone replacement but may be lower risk than alternative forms. During andropause, the risk of not receiving adequate hormone therapy can outweigh the risks of replacing testosterone.

Risks of not receiving testosterone therapy after andropause include but are not limited to:
Arteriosclerosis, elevation of cholesterol, obesity, loss of strength and stamina, generalized aging, osteoporosis, mood disorders, depression, arthritis, loss of libido, erectile dysfunction, loss of skin tone, diabetes, increased overall inflammatory processes, dementia and Alzheimer's disease, and many other symptoms of aging.

CONSENT FOR TREATMENT: I consent to the insertion of testosterone pellets in my hip. 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.**

Side effects may include: Bleeding, bruising, swelling, infection and pain. Lack of effect (typically from lack of absorption). Thinning hair, male pattern baldness. Increased growth of prostate and prostate tumors. Extrusion of pellets. Hyper sexuality (overactive libido). Ten to fifteen percent shrinkage in testicle size. There can also be a significant reduction in sperm production.

There is some risk, even with natural testosterone therapy, of enhancing an existing current prostate cancer to grow more rapidly. For this reason, a prostate specific antigen blood test is to be done before starting testosterone pellet therapy and will be conducted each year thereafter. If there is any question about possible prostate cancer, a follow-up with an ultrasound of the prostate gland may be required as well as a referral to a qualified specialist. While urinary symptoms typically improve with testosterone, rarely they may worsen, or worsen before improving. Testosterone therapy may increase one's hemoglobin and hematocrit, or thicken one's blood. This problem can be diagnosed with a blood test. Thus, a complete blood count (Hemoglobin and Hematocrit.) 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 (secondary to hormonal decline). Decreased weight (Increase in lean body mass). Decrease in risk or severity of diabetes. Decreased risk of Alzheimer's and Dementia. Decreased risk of heart disease in men less than 75 years old with no pre-existing history of heart disease.

On January 31, 2014, the FDA issued a Drug Safety Communication indicating that the FDA is investigating risk of heart attack and death in some men taking FDA approved testosterone products. The risks were found in men over the age of 65 years old with pre-existing heart disease and men over the age of 75 years old with or without pre-existing heart disease. These studies were performed with testosterone patches, testosterone creams and synthetic testosterone injections and did not include subcutaneous hormone pellet therapy.

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 agree to immediately report to my practitioner's office any adverse reactions or problems that may be related to my therapy. Potential complications have been explained to me and I agree that I have received information regarding those risks, potential complications and benefits, and the nature of bio-identical and other treatments and have had all my questions answered. Furthermore, I have not been promised or guaranteed any specific benefits from the administration of bio-identical therapy. I certify this form has been fully explained to me, and I have read it or have had it read to me and I understand its contents. 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 insertions.

I understand that payment is due in full at the time of service. I also understand that it is my responsibility to submit a claim to my insurance company for possible reimbursement. I have been advised that most insurance companies do not consider pellet therapy to be a covered benefit and my insurance company may not reimburse me, depending on my coverage. 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.

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INSURANCE DISCLAIMER

Preventative medicine and bio-identical hormone replacement is a unique practice and is considered a form of alternative medicine. Even though the physicians and nurses are board certified as Medical Doctors and RN's or NP's, insurance does not recognize it as necessary medicine BUT is considered like plastic surgery (esthetic medicine) and therefore is not covered by health insurance in most cases.

YOU. Designer Health is not associated with any insurance companies, which means they are not obligated to pay for our services (blood work, consultations, insertions or pellets). We require payment at time of service and, if you choose, we will provide a form to send to your insurance company and a receipt showing that you paid out of pocket. WE WILL NOT, however, communicate in any way with insurance companies.

The form and receipt are your responsibility and serve as evidence of your treatment. We will not call, write, pre-certify, or make any contact with your insurance company. Any follow up letters from your insurance to us will be thrown away. If we receive a check from your insurance company, we will not cash it, but instead return it to the sender. Likewise, we will not mail it to you. We will not respond to any letters or calls from your insurance company.

For patients who have access to Health Savings Account, you may pay for your treatment with that credit or debit card. This is the best idea for those patients who have an HSA as an option in their medical coverage.

PRINT NAME _____ SIGNATURE _____ TODAY'S DATE _____

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HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA 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. HIPAA 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 or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ Date: _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

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bioTE® MEDICAL

COMMONLY ASKED QUESTIONS

Q. What is BioTE®?

A. BioTE® is a Bio-Identical form of hormone therapy that seeks to return the hormone balance 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'm on birth control?

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 is temporary and typically only happens on the first dose. All are very treatable. There are no serious side effects.

Q. What if I'm 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.

YOU. DESIGNER HEALTH

8206 Vicksburg Ave. STE A | Lubbock, TX 79424
Phone: 806.401.0460 Fax: 855-490-4610
youdesignerhealth.com

MAMMOGRAM WAIVER FOR TESTOSTERONE AND/OR ESTRADIOL PELLET THERAPY

I, X _____, voluntarily choose to undergo implantation of
PATIENT NAME

subcutaneous bio-identical testosterone and/or estradiol pellet therapy, even though I am not current on my yearly mammogram. I understand that such therapy is controversial and that many doctors believe that estradiol replacement in my case is contraindicated. My Treating Provider has informed me it is possible that taking estradiol could possibly cause cancer, or stimulate existing breast cancer (including one that has not yet been detected). Accordingly, I am aware that breast cancer or other cancer could develop while on pellet therapy.

For today's appointment, I I DO NOT have a mammogram for the following reason:

- ☐ My decision not to have one.
- ☐ Unable to provide the report at this time.
- ☐ My doctor's decision not to have one. Please provide a note from your treating physician with their rationale as to why they don't want you to have a mammogram.

I am aware that a current report must be sent by mail or faxed to our office prior to my next HRT appointment. The Treating Provider has discussed the importance and necessity of a mammogram since I receive testosterone and/or estradiol.

Patient Initial: X _____

I have assessed this risk on a personal basis, and my perceived value of the hormone therapy outweighs the risk in my mind. I am, therefore, choosing to undergo the pellet therapy despite the potential risk that I was informed of by my Treating Provider.

I understand that mammograms are the best single method for detection of early breast cancer. I understand that my refusal to submit to a mammogram test may result in cancer remaining undetected within my body. I acknowledge that I bear full responsibility for any personal injury or illness, accident, risk or loss (including death and/or breast, uterine or cancer issues) that may be sustained by me in connection with my decision to not have a mammogram and undergo testosterone and/or estradiol pellet therapy including, without limitation, any cancer that should develop in the future, whether it be deemed a stimulation of a current cancer or a new cancer. I hereby release and agree to hold harmless Dr. Donovitz, Treating Provider, BioTE® Medical, LLC., and any of their BioTE® Medical physicians, nurses, officers, directors, employees and agents from any and all liability, claims, demands and actions arising or related to any loss, property damage, illness, injury or accident that may be sustained by me as a result of testosterone and/or estradiol pellet therapy. I acknowledge and agree that I have been given adequate opportunity to review this document and to ask questions. This release and hold harmless agreement is and shall be binding on myself and my heirs, assigns and personal representatives

PRINT NAME _____ SIGNATURE _____ TODAY'S DATE _____

YOU. DESIGNER HEALTH

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PAP & TRANSVAGINAL ULTRASOUND WAIVER FOR TESTOSTERONE AND/OR ESTRADIOL PELLET THERAPY

I, X _____, voluntarily choose to undergo implantation of
PATIENT NAME

subcutaneous bio-identical estradiol pellet therapy.

For today's appointment, I I DO NOT have a PAP Smear for the following reason:

- ☐ My decision not to have one.
- ☐ Unable to provide the report at this time.
- ☐ My doctor's decision not to have one. Please provide a note from your treating physician with their rationale as to why they don't want you to have a PAP Smear.

For today's appointment, I I DO NOT have a Transvaginal Ultrasound for the following reason:

- ☐ My decision not to have one.
- ☐ Unable to provide the report at this time.
- ☐ My doctor's decision not to have one. Please provide a note from your treating physician with their rationale as to why they don't want you to have a Transvaginal Ultrasound.

I am aware that a current report must be sent by mail or faxed to our office prior to my next HRT appointment. The Treating Provider has discussed the importance and necessity of a mammogram since I receive testosterone and/or estradiol.

Patient Initial: X _____

I have assessed this risk on a personal basis, and my perceived value of the hormone therapy outweighs the risk in my mind. I am, therefore, choosing to undergo the pellet therapy despite the potential risk that I was informed of by my Treating Provider.

I understand that PAP smear and/or Transvaginal Ultrasounds are the best single method for detection of early ovarian, endometrial and/or cervical cancer. I understand that my refusal to submit to a Pap smear and/or Transvaginal Ultrasound may result in cancer remaining undetected within my body. I acknowledge that I bear full responsibility for any personal injury or illness, accident, risk or loss (including death and/or cervical, endometrial and/or ovarian cancer issues) that may be sustained by me in connection with my decision to not have a PAP Smear and/or Transvaginal Ultrasound and undergo testosterone and/or estradiol pellet therapy including, without limitation, any cancer that should develop in the future, whether it be deemed a stimulation of a current cancer or a new cancer. I hereby release and agree to hold harmless Dr. Donovitz, Treating Provider, BioTE® Medical, LLC., and any of their BioTE® Medical physicians, nurses, officers, directors, employees and agents from any and all liability, claims, demands and actions arising or related to any loss, property damage, illness, injury or accident that may be sustained by me as a result of testosterone and/or estradiol pellet therapy. I acknowledge and agree that I have been given adequate opportunity to review this document and to ask questions. This release and hold harmless agreement is and shall be binding on myself and my heirs, assigns and personal representatives

PRINT NAME _____ SIGNATURE _____ TODAY'S DATE _____

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PROSTATE EXAM WAIVER FOR TESTOSTERONE PELLET THERAPY

I, X _____, voluntarily choose to undergo implantation of
PATIENT NAME

subcutaneous bio-identical testosterone pellet therapy with, YOU. Designer Health.

For today's appointment, I have not provided you with a prostate exam report, due to the following reason:

☐ My decision not to have a prostate exam.

☐ I am unable to provide it at this time.

☐ I am aware that a current report must be sent by mail or faxed to our office prior to my next HRT appointment. The Treating Provider has discussed the importance and necessity of prostate exam since I receive testosterone.

Patient Initial: X _____

A prostate exam is the best single method for detection of early prostate cancer. I understand that my refusal to submit to a prostate exam may result in cancer remaining undetected within my body. Hormone therapy may increase the risk of increase of such undetected cancer.

I acknowledge that I bear full responsibility for any personal injury or illness, accident, risk or loss (including death and/or prostate issues) that may be sustained by me in connection with my decision to undergo testosterone pellet therapy including, without limitation, any cancer that should develop in the future, whether it be deemed a stimulation of a current cancer or a new cancer. I hereby release and agree to hold harmless Dr. Donovitz, Treating Provider, BioTE® Medical, LLC., and any of their BioTE® Medical physicians, nurses, officers, directors, employees and agents from any and all liability, claims, demands and actions arising or related to any loss, property damage, illness, injury or accident that may be sustained by me as a result of testosterone pellet therapy. I acknowledge and agree that I have been given adequate opportunity to review this document and to ask questions. This release and hold harmless agreement is and shall be binding on myself and my heirs, assigns and personal representatives

PRINT NAME _____ SIGNATURE _____ TODAY'S DATE _____