Health Assessment for Women

Which of the following symptoms apply at this time?

Place an "X" for EACH symptom. For symptoms that do not apply, please mark NONE.

Name:_____ **DOB:**_____ **Height:**_____ **Weight:**_____

Activity Level:	**Low**	**Average**	**High**
History of breast cancer?	**Yes**	**No**	**If yes when?**_____
History of fibrocystic breast disease?	**Yes**	**No**	**If yes when?**_____
History of PCOS?	**Yes**	**No**	**If yes when?**_____
Have you had a Hysterectomy?	**Yes**	**No**	**If yes when?**_____
Are you still having Menstrual Cycles?	**Yes**	**No**	
Do you get Menstrual Migraines?	**Yes**	**No**	
Are you Currently on Birth Control?	**Yes**	**No**	
What form of birth control are you currently using?_____			
Are you experiencing weight gain?	**Yes**	**No**	
Have you had chronic fatigue?	**Yes**	**No**	
Current Smoker?	**Yes**	**No**	
Are you currently on Hormone Replacement Therapy?	**Yes**	**No**	**If yes when?**_____ **Dose**_____
Have you ever been on Hormone Replacement Therapy?	**Yes**	**No**	**If yes when?**_____

	None	**Mild**	**Moderate**	**Severe**	**Extremely Severe**
1. **Hot flashes, Night Sweats** (episodes of sweating)	☐	☐	☐	☐	☐
2. **Heart discomfort** (unusual awareness of heart beat, heart skipping, heart racing, tightness)	☐	☐	☐	☐	☐
3. **Sleep Problems** (difficulty in falling asleep, difficulty in sleeping through the night, waking up early)	☐	☐	☐	☐	☐
4. **Depressive mood** (feeling down, sad, on the verge of tears, lack of drive, mood swings)	☐	☐	☐	☐	☐
5. **Irritability** (feeling nervous, inner tension, feeling aggressive)	☐	☐	☐	☐	☐
6. **Anxiety** (inner restlessness, feeling panicky)	☐	☐	☐	☐	☐
7. **Physical and mental exhaustion** (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)	☐	☐	☐	☐	☐
8. **Sexual problems** (change in sexual desire, in sexual activity and satisfaction)	☐	☐	☐	☐	☐
9. **Bladder problems** (difficulty in urinating, increased need to urinate, bladder incontinence)	☐	☐	☐	☐	☐
10. **Vaginal dryness** (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)	☐	☐	☐	☐	☐
11. **Joint and muscular discomfort** (pain in the joints, rheumatoid complaints)	☐	☐	☐	☐	☐

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NEW Female Patient Intake Form

Name:_____ DOB:_____ Date:_____

Address:_____

City:_____ State:_____ Zip:_____

Cell Phone:_____ Email:_____

Would you like to receive SMS appt reminders? ☐ Yes ☐ No Mobile Carrier: _____

Emergency Contact:_____ Phone:_____

How did you hear about us?_____

MEDICAL HISTORY

Current Height: _____ Weight: _____ Age: _____

Please check all that apply:

☐ Bleeding Disorders
☐ Problems with scarring/Keloids
☐ Cancer (Specify): _____
☐ Diabetes: ☐ Type I ☐ Type II
☐ Heart Disease
☐ High Cholesterol
☐ HIV/AIDS
☐ Hepatitis: ☐ A ☐ B ☐ C
☐ Pacemaker/Defibrillator
☐ Polycystic Ovarian Syndrome
☐ Auto-Immune (Specify): _____
☐ Seizures
☐ Acne
☐ Cold Sores/Herpes
☐ Rosacea
☐ Precancerous Lesions
☐ Currently Pregnant or Nursing
☐ Accutane/Isotretinoin (when): _____
☐ Stress Urinary Incontinence
☐ Thyroid Disease
☐ Facial Surgeries
☐ Tattoos (areas): _____
☐ Other:_____
☐ Allergies:_____
_____

Are you currently under the care of a Physician for any medical conditions? ☐ Yes ☐ No
If yes, please explain: _____
Do you see a dermatologist regularly? ☐ Yes ☐ No
When was your last full skin exam? _____
Do you wear sunscreen daily? ☐ Yes ☐ No What SPF? _____

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.

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.

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NEW Patient Intake Form

INTERESTS

Please check any of the following conditions that you may be experiencing:

- ☐ Aging Skin
- ☐ Acne
- ☐ Wrinkles/Fine Lines
- ☐ Brown Spots/UV Damage
- ☐ Enlarged Pores
- ☐ Rough Texture
- ☐ Unwanted Hair
- ☐ Redness/Rosacea
- ☐ Spider Veins
- ☐ Sagging Skin/Laxity
- ☐ Unwanted Fat
- ☐ Cellulite
- ☐ Scars
- ☐ Thinning Hair
- ☐ Low Libido
- ☐ Erectile Dysfunction
- ☐ Vaginal Dryness/Laxity
- ☐ Painful Intercourse
- ☐ Brain Fog
- ☐ Mood Swings
- ☐ Melasma
- ☐ Stress Urinary Incontinence
- ☐ Joint/Muscle Pain
- ☐ Irritability/Anxiety
- ☐ Fatigue/Low Energy
- ☐ Decreased Sexual Performance/Satisfaction
- ☐ Other:_____

Please check any of the following services you are interested in:

- ☐ Botox/Dysport
- ☐ Dermal Filler
- ☐ M spa Signature facial
- ☐ Laser Resurfacing
- ☐ Laser Hair Removal
- ☐ Acne Laser Therapy
- ☐ Skin Tightening
- ☐ Cool Sculpting
- ☐ Cooltone
- ☐ Chemical Peels
- ☐ Microneedling
- ☐ Dermaplaning
- ☐ Hormone Replacement
- ☐ PDO thread lift
- ☐ Platelet-Rich Plasma
- ☐ Cellulite Reduction
- ☐ Pellet Therapy
- ☐ Thyroid Optimization
- ☐ Exosome Treatments
- ☐ Secret RF Microneedling with Radio Frequency

What other procedures are you interested in?_____

What cosmetic procedures have you had in the past? _____

Please list any at-home skincare products you are currently using: _____

_____

FINANCIAL AGREEMENT

24 Hour cancellation and "No Show" policy

Please note that once you have booked an appointment with us it means that we have reserved time in our schedule exclusively for you. M Spa Face & Body charges a fee of $75.00 for all missed appointments ("No Shows") and/or cancelled appointments without a 24-hour advance notice.

I understand that payment is due in full upon completion of any service. Certain services, such as Laser Treatments, Sexual Wellness, Pellets and Cool Sculpting, require a non-refundable deposit to book.

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

Print Name	Signature	Today's Date

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Female Medical History

Any known drug allergies:_____

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:_____

Last menstrual period (estimate year if unknown):_____

Other Pertinent Information:_____

Preventative Medical Care:

- ☐ Medical/GYN exam in the last year.
- ☐ Mammogram in the last 12 months.
- ☐ Bone density in the last 12 months.
- ☐ Pelvic ultrasound in the last 12 months.

High Risk Past 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:_____

Medical Illnesses:

- ☐ Polycystic Ovary Syndrome(PCOS)
- ☐ High blood pressure.
- ☐ Heart bypass.
- ☐ High cholesterol.
- ☐ Hypertension.
- ☐ Heart disease.
- ☐ Stroke and/or heart attack.
- ☐ Blood clot and/or a pulmonary emboli.
- ☐ Arrhythmia.
- ☐ Any form of Hepatitis or HIV.
- ☐ Lupus or other auto immune disease.
- ☐ Fibromyalgia.
- ☐ Trouble passing urine or take Flomax or Avodart.
- ☐ Chronic liver disease (hepatitis, fatty liver, cirrhosis).
- ☐ Diabetes.
- ☐ Thyroid disease.
- ☐ Arthritis.
- ☐ Depression/anxiety.
- ☐ Psychiatric disorder.
- ☐ Cancer (type):_____
  Year: _____

_____ _____ _____

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

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HIPAA Information & Consent

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 appropriatefor your care. Patient files may be stored in open file racks and will not contain any coding which identifies apatient'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 documentsor information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, US 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 orservices.
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 incertain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, 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.

Print Name	Signature	Today's Date

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Female Testosterone/Estradiol Pellet Insertion Consent

Bio-identical hormone pellets are hormones, biologically identical to the hormones you make in your own body prior to menopause. Estrogen and testosterone were 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 did when you were younger, without the monthly fluctuations (ups and downs) of menstrual cycles.

Bio-identical hormone pellets are plant derived 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 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; reaction to local anesthetic and/or preservatives; 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 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

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OFF-LABEL Thyroid Consent

Off-Label Medication Information

Medication: Desiccated Thyroid Extract

FDA Approved Use: Hypothyroidism, Thyroid Cancer

Off-Label Use: Symptoms associated with low thyroid

Desiccated thyroid extract (Armour Thyroid, NP Thyroid, WP Thyroid, Westhroid, NatureThroid) is an extract of thyroid hormone that comes from pigs. It is FDA approved for use in hypothyroidism and in some types of thyroid cancer. The off-label uses have not been evaluated by the FDA and any claims of benefit are purely educated opinions that come from consideration of various medical research studies.

The American Academy of Clinical Endocrinology guidelines do not provide for the use of this medication for anything other than hypothyroidism. For any approved use of this medication, the AACE guidelines also state that the preferred medication is levothyroxine (Synthroid).

Thyroid hormone, in the medical research, has been shown to improve fatigue, fibromyalgia, cholesterol, glucose metabolism, hair loss, weight, and other conditions. It has been used to treat infertility also. The proposed mechanism of improvement of fertility is through treatment of a condition called polycystic ovarian syndrome (PCOS).

Thyroid hormone, in excessive doses can cause elevated blood pressure, anxiety, heart racing, irregular heartbeat, excessive weight loss, and, in very extreme cases, prominence of the eyes (exophthalmos). Thyroid hormone, taken by people who have a normally functioning thyroid gland, for extended periods of time, can cause normal thyroid function to decline, necessitating lifelong treatment with this medication.

AACE guidelines define hypothyroidism as a TSH (lab test, thyroid stimulating hormone) greater than 4. In some cases, TSH greater than 2.5 can be hypothyroidism. If your TSH isn't above these ranges, then you do NOT have a diagnosis of hypothyroidism. There are other thyroid tests that can be considered. These tests, while helpful in making a treatment decision, are not considered to be the standard.

Once treatment with this medication is begun, you are asked to please call the office with any concerns. If you have any adverse reaction to the medication, stop it and call immediately.

Frequent adjustments are required to fine tune the treatment with this type of medication. Periodic blood tests are necessary to determine if the dose needs to be adjusted.

Goals for treatment with this medication will be discussed at each lab results appointment. If goals are met, then maintenance doses will be discussed. If the treatment is not as effective as anticipated, it might be discontinued. At that time, alternative therapies will be discussed.

You are welcome to seek a second opinion or a specialist consultation. As stated above, understand that other physicians, even specialists, might not agree with or understand the goal of this type of treatment.

I have read and agree to the above. My questions have been answered and I understand the treatment and goals. I hereby release and agree to hold harmless **M Spa Face & Body** and any of their 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.

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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Frequently Asked Questions

Q. What is Hormone Pellet Therapy?
A. Bio-Identical hormone pellet therapy uses natural hormones that help to return your hormone balance to the protective levels found in younger 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. The blood work you are having done will help to determine your hormone levels. After our provider reviews your labs and determines that you are a candidate, we will schedule a consultation and pellet insertion appointment.

Q. Do I have blood work done before each Treatment?
A. No, only initially and 5-6 weeks later to set your dosing. Sometimes we need to draw labs again to help us evaluate changes based on how your body metabolizes.

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. We used Pellets sourced only with Wild Yams because it creates the highest quality.

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 provider will implant the pellets in the fat under the skin of the hip or flank. After using lidocaine to numb the area, a small incision is made and the pellets are inserted using a special medical device.

Q. Does it matter if I'm on birth control?
A. No, your provider 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. No problem, this is an easy transition. We 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 our practitioner.

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Hormone Replacement Fee Acknowledgment

Although more insurance companies are reimbursing patients for the Hormone Replacement 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.

***Female BHRT Lab Panel:**	**$250** (estimated)
***New Patient Consult Fee/Return Visits**	**$150**
Female Hormone Pellet Insertion Fee:	**$400**

**** These items may be covered by your insurance - your standard deducibles/copays and coinsurances apply.***

WE DO NOT FILE INSURANCE ON THIS PROCEDURE - IT IS OUT OF NETWORK

We accept the following forms of payment:

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

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.

M Spa Face & Body 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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OFFICE USE ONLY – Initial Pellet Insertion Female

INSERTION DATE: _____

NAME: _____ DOB: _____

Height: _____ Weight: _____ Blood Pressure: _____ Temperature: _____

CURRENT MEDICATIONS: _____ OCP Method: _____

SURGERY/ HISTORY: Hysterectomy: ( ) YES ( ) NO Oophorectomy: ( ) YES ( ) NO

Last Menstrual Period: _____ Last Pap: _____ Last Mammogram: _____ Normal: ( ) YES ( ) NO

SYMPTOMS: _____

LABS:

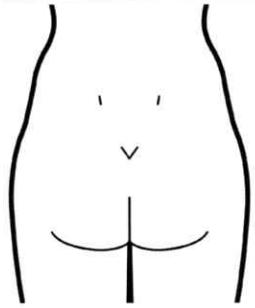
Estradiol: _____ Testosterone: _____ Free T: _____ FSH: _____

Free T3: _____ TSH: _____ TPO: _____ Ferritin: _____

Vitamin D: _____ Vitamin B12: _____ CBC: _____

Chem Panel: _____ LDL: _____ HDL: _____ Triglycerides: _____

Insertion site:
Left Hip ( ) Right Hip ( )



PLAN:

This patient presents today for hormone pellets. The procedure, risks, benefits and alternatives were explained to the patient. Questions were answered and a consent form for the insertion of Testosterone and/or Estradiol pellet implants was signed. An area in the hip was prepped with Chloraprep swabs. A sterile drape was applied. 1% Lidocaine with epinephrine and sodium bicarbonate was injected to anesthetize the area. A small transverse incision was made using a number 11 blade. The trocar with cannula was passed through the incision into the subcutaneous tissue. Testosterone and or Estradiol pellet(s) were inserted through the cannula into the subcutaneous tissue. Bleeding was minimal. Steri-strips were applied. A sterile dressing was applied. The patient tolerated the procedure well. Postoperative instructions were reviewed and a copy given to the patient. Pellets used are as follows:

TREAT WITH:

Testosterone: _____mg Testosterone Lot Numbers: _____

Estradiol: _____mg Estradiol Lot Numbers: _____

Thyroid: ☐ 1 grain ☐ 1 1/2 grains ☐ 2 grains ☐ 2 1/2 grains ☐ 3 grains ☐ other _____ ☐ BID

Micronized Progesterone: ☐ 100mg ☐ 200mg ☐ add 100mg to regular dose for *CIRCLE ONE* breakthrough bleeding or heavy mensies

Spironolactone: ☐ 100mg Daily ☐ other _____ Finasteride: ☐ 1mg Daily ☐ other _____

Melatonin: ☐ 3mg ☐ 5mg ☐ 10mg ☐ 20mg ☐ other _____

HRT Complete T _____ a day HRT Complete E _____ a day

ADK (Vitamins A, D3 and K2) ☐ 5,000 IU ☐ 10,000 IU _____ a day for _____ weeks ☐ then one a day

PROBIOTIC ☐ 1 a day ☐ other _____

Iodine: _____ Omega 3: _____ DIM: _____

Other: _____

COMMENTS: _____

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What Might Occur After 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.

- **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.

- **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:** 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.

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

Print Name	Signature	Today's Date

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Post-Insertion Instructions for Women

- Your insertion site has been covered with two layers of bandages. Remove the outer pressure bandage any time after 24 hours. 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 **3 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.
- Do not take tub baths or get into a hot tub or swimming pool for 3 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 **3 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 Benadryl for relief, 50 mg. 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 **5-6 weeks** after the 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.

Print Name	Signature	Today's Date
_____	_____	_____

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Female Treatment Plan

The following supplements are recommended to maximize your pellet therapy.

Patients report that they feel best when taking the **KEY THREE: HRT COMPLETE, ADK, & PROBIOTIC**

Unless 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.

_____ HRT Complete T Take _____ a day

_____ HRT Complete E Take _____ a day

_____ ADK (Vitamins A, D3 and K2) *(fat soluble and best taken with OMEGA or fatty meal)*

☐ **5,000 IU** take _____ a day for_____weeks ☐ then one a day

☐ **10,000 IU** take _____ a day for_____weeks ☐ then one a day

_____ PROBIOTIC Take 1 a day for one week, then take 2 a day starting week 2

_____ OMEGA Take 1 - 4 softgels daily with meal

_____ Iron BIS Take 1 - 2 capsules daily with meal

_____ IODINE Complete 12.5 mg daily with food or as directed by physician

_____ DIM Take _____ in the AM and _____ in the PM

_____ Methyl B Complex Take _____ a day

PRESCRIPTIONS: These have been called into your preferred pharmacy

☐ Progesterone/Prometrium ☐ 100mg ☐ 200mg ☐ add 100mg to regular dose for breakthrough bleeding

Please do not skip doses of this medication as it can result in vaginal bleeding or an increased risk for endometrial cancer.

IF YOU GET A GENERIC YOU MAY START BLEEDING

☐ Nature-Throid ☐ 1/2 grain ☐ 1 grain ☐ 1 1/2 grains ☐ 2 grains ☐ 2 1/2 grains ☐ 3 grains ☐ other _____

☐ once ☐ twice a day - upon waking and at 1pm or an hour after lunch.

☐ Every _____ days add 1/2 grain until you feel good.

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 Protocol Synthroid/Levothyroxine ***(Consider starting at 1 grain)***: **alternate your desiccated thyroid (Nature-Throid) every other day with Synthroid/Levothyroxine for 3 weeks then go to every day on your desiccated thyroid.**

☐ Melatonin ☐ 10mg ☐ 20mg ☐ 30mg ☐ 40mg ☐ 50mg ☐ 60mg ☐ 40mg **Take one pill by mouth daily at bedtime.**

☐ Spironolactone ☐ 100mg Daily ☐ other _____

☐ Finasteride ☐ 1mg ☐ 5mg **Take one pill by mouth daily.**

☐ Wean off your antidepressant ***(see wean protocol)*** _____ (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.

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PAP & Transvaginal Waiver for Testosterone and/or Estradiol Pellet Therapy

I voluntarily choose to undergo implantation of subcutaneous bio- identical testosterone and/or estradiol pellet therapy.

( ) For today's appointment 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 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 Pap smear and/or Transvaginal Ultrasound since I receive testosterone and/or estradiol. _____(initials of patient)

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 **M Spa Face & Body** and any of their practitioners, 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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Breast Cancer Waiver for Estradiol Pellet Therapy

I voluntarily choose to undergo implantation of subcutaneous bio-identical estradiol pellet therapy, even though I have a history of breast cancer. 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.

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 acknowledge that I bear full responsibility for any personal injury or illness, accident, risk or loss (including death and/or cancer issues) that may be sustained by me in connection with my decision to undergo 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 **M Spa Face & Body**, and any of their practitioners, 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 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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Ovarian Cancer Waiver for Estradiol Pellet Therapy

I voluntarily choose to undergo implantation of subcutaneous bio-identical estradiol pellet therapy, even though I have a history of ovarian cancer. 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 Testosterone and/or Estradiol could possibly cause cancer, or stimulate existing ovarian cancer (including one that has not yet been detected). Accordingly, I am aware that ovarian cancer or other cancer could develop while on pellet therapy.

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 acknowledge that I bear full responsibility for any personal injury or illness, accident, risk or loss (including death and/or cancer issues) that may be sustained by me in connection with my decision to 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 **M Spa Face & Body**, and any of their practitioners, 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 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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Mammogram Waiver for Testosterone/Estradiol Pellet Therapy

I voluntarily choose to undergo implantation of subcutaneous bio-identical estradiol hormone pellet therapy, even though I am not current on my yearly mammogram.

My treating Provider has discussed the importance and necessity of a mammogram since I receive hormone pellet therapy.

My treating Provider has informed that taking estradiol could possibly cause cancer or stimulate existing breast cancer (including one that has not yet been detected). Testosterone may also convert in the body to estradiol, offering some risk to exposure. Accordingly, I am aware that breast cancer could develop while on pellet therapy.

I understand that my refusal to submit to a mammogram test may result in cancer remaining undetected within my body.

For today's appointment 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.

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 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 hormone 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 **M Spa Face & Body** and any of their practitioners, 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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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.

The Procedure CPT Code is: 11980

M Spa Face & Body 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, we will provide a receipt showing that you paid out of pocket. WE WILL NOT, however, communicate in any way with insurance companies.
Pellet insertion procedures can only be processed as out of network.

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.

Instructions on filing your insurance for reimbursement

1. Obtain your insurance form from your insurance company (usually from their website)
2. Make three copies of the LETTER OF MEDICAL NECESSITY, SUPERBILL, and COMPLETED CLAIM FORM (from insurance website)
3. Mail one of each of the above documents to the claims address on the back of your insurance card.
4. Call your insurance company in 3 weeks to verify they have received your claim and the status. Document the name of the person you speak with.
5. If they do not have a claim on file yet, ask if you can fax the claim to them and/or verify the mailing address. Send the second set of documents.
6. Repeat steps 4 and 5 until your claim is processed and paid. Not all insurances will cover this therapy since pellets are compounded to individualize your dose.
7. You must have "OUT OF NETWORK" benefits for this to be reimbursed by your insurance and have met the "OUT OF NETWORK" deductible.

Print Name _____ Signature _____ Today's Date _____

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Antidepressant Wean Protocol

If you are taking an SSRI or SNRI antidepressant such as Prozac, Zoloft, Lexapro, Pristiq, Effexor, Viibryd or others, we recommend you wean off of these slowly as soon as you start to feel better with your pellets.

These antidepressants have many side effects. You can feel tired, sleepy, have weight gain or difficulty achieving an orgasm (to name a few). Everything we are trying to improve.

The truth is, you are NOT deficient in these medications. You are deficient in testosterone. As we restore your testosterone levels to normal with pellets your symptoms of anxiety and/or depression should be relieved naturally. You should be able to wean off your antidepressant.

Go slow! Especially if you have been taking them for a while. While taking an SSRI or SNRI your brain relies on these medications to get serotonin (the calming, feel good hormone) and doesn't make it's own. If you stop abruptly, you can go through withdrawal. Symptoms of abrupt cessation may include headache, GI distress, faintness, body aches, chills, and strange sensations of vision or touch. You may also experience depression or anxiety symptoms returning. When you wean slowly, your brain has time to catch up, wake up, and start making its own serotonin again.

We recommend the following protocol to help:

1. **Take your pill every other day for 2 weeks.**
2. **Then every 3 days for 2 weeks.**
3. **Then every 4 days for 2 weeks and so on until you are down to one a week, then STOP.**

*******If at any point you feel bad or "off", go back to the lowest dose you felt good on and take the wean a bit slower.**

Please call us with any questions.

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