Health Assessment for Men

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**
Current smoker?	**Yes**	**No**	
History of prostate cancer?	**Yes**	**No**	**If yes when?**_____
History of enlarged prostate?	**Yes**	**No**	**If yes when?**_____
Have you had a urological work up?	**Yes**	**No**	**If yes when?**_____
Do you take medication for hair loss?	**Yes**	**No**	**If yes what are you taking?**_____
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. **Decline in your feeling of general well-being** (general state of health, subjective feeling)	☐	☐	☐	☐	☐
2. **Body Aches** (lower back pain, joint pain, pain in a limb, general back ache)	☐	☐	☐	☐	☐
3. **Excessive sweating** (unexpected/sudden episodes of sweating, hot) flushes independent of physical strain),	☐	☐	☐	☐	☐
4. **Sleep problems** (difficulty in falling asleep difficulty in sleeping) waking up early and feeling tired, poor sleep, sleeplessness)	☐	☐	☐	☐	☐
5. **Increased need for sleep, often feeling tired**	☐	☐	☐	☐	☐
6. **Irritability** (feeling aggressive, easily upset about) little things,	☐	☐	☐	☐	☐
7. **Nervousness** (inner tension, restlessness, feeling fidgety)	☐	☐	☐	☐	☐
8. **Anxiety (feeling panicky)**	☐	☐	☐	☐	☐
9. **Physical exhaustion / lacking vitality** (general decrease in performance, reduced activity, lacking interest in leisure activities, having to force oneself to undertake activities)	☐	☐	☐	☐	☐
10. **Decrease in muscular strength** (feeling of weakness)	☐	☐	☐	☐	☐
11. **Depressive mood** (feeling down, sad, on the verge of tears lack of drive, mood swings, feeling nothing is of any use)	☐	☐	☐	☐	☐
12. **Decrease in beard growth**	☐	☐	☐	☐	☐
13. **Decrease in ability/frequency to perform sexually**	☐	☐	☐	☐	☐
14. **Decrease in the number of morning erection**	☐	☐	☐	☐	☐
15. **Decrease in sexual desire/libido** (lacking pleasure in sex, lacking desire for sexual)	☐	☐	☐	☐	☐

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Sexual Health Inventory for Men (SHIM)

This questionnaire can help you and your doctor determine if you have symptoms of erectile dysfunction (ED). For each question, circle the number next to the response that best describes your experience. Then add these numbers together and refer to the table below to see what your score may mean. Remember, only your doctor can determine if you have ED.

Over the past 6 months:

1. How do you rate your confi dence that you could get and keep an erection?

1. Very low 2. Low 3. Moderate 4. High 5. Very high

2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?

0. No sexual activity 1. Almost never or never 2. A few times (much less than half the time) 3. Sometimes (about half the time) 4. Most times (much more than half the time) 5. Almost always or always

3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?

0. Did not attempt intercourse 1. Almost never or never 2. A few times (much less than half the time) 3. Sometimes (about half the time) 4. Most times (much more than half the time) 5. Almost always or always

4. During sexual intercourse, how diffi cult was it to maintain your erection to completion of intercourse?

0. Did not attempt intercourse 1. Extremely diffi cult 2. Very diffi cult 3. Diffi cult 4. Slightly diffi cult 5. Not diffi cult

5. When you attempted sexual intercourse, how often was it satisfactory for you?

0. Did not attempt intercourse 1. Almost never or never 2. A few times (much less than half the time) 3. Sometimes (about half the time) 4. Most times (much more than half the time) 5. Almost always or always

SHIM Total Score _____

1-7 Severe ED

8-11 Moderate ED

12-16 Mild moderate ED

17-21 Mild ED

22-25 No ED

_____ _____

Name **Date**

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Male Patient Questionaire & History

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:_____

_____

Previous Surgeries: _____

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.

_____
Patient Initials

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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
- ☐ Painful Intercourse
- ☐ Brain Fog
- ☐ Mood Swings
- ☐ Melasma
- ☐ 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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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:_____

Other Pertinent Information:_____

_____

MEDICAL ILLNESSES:

- ☐ High blood pressure.
- ☐ 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.
- ☐ Testicular or prostate cancer.
- ☐ Elevated PSA
- ☐ Prostate Enlargement
- ☐ Cancer (type):_____
  Year: _____
- ☐ Other:_____

I understand that if I begin testosterone replacement with any testosterone treatment, including testosterone pellets, that I will produce less testosterone from my testicles and if I stop replacement, I may experience a temporary decrease in my testosterone production. Testosterone Pellets should be completely out of your system in 12 months.

By beginning treatment, I accept all the risks of therapy stated herein and future risks that might be reported. I understand that higher than normal physiologic levels may be reached to create the necessary hormonal balance.

Print 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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Male Testosterone Pellet Insertion Consent

Bio-identical testosterone pellets are 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 did when you were younger. Bio-identical hormone pellets are plant derived 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, pain, reaction to local anesthetic and/or preservatives, 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 and 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.

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; and 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 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

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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: _____

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 practitioner 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.

***Male BHRT Lab Panel:**	**$250** (estimated)
***New Patient Consult Fee/Return Visits**	**$150**
Male Hormone Pellet Insertion Fee > 2000mg:	**$700**

**** 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 Male

INSERTION DATE: _____

NAME: _____ DOB: _____

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

CURRENT MEDICATIONS: _____

SURGERY/ PAST MEDICAL HISTORY: _____

SYMPTOMS: _____

LABS:

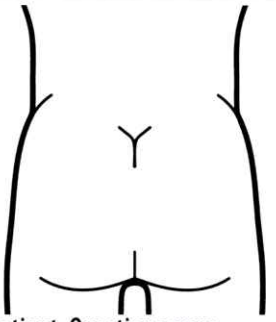
Testosterone: _____ Free T: _____ Free T3: _____

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: _____

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

Finasteride: ☐ 1mg daily ☐ 5mg daily.

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

Clomiphene Citrate ☐ 1 mg daily for _____ days.

Arginine/Sildenafil ☐ 70mg/363mg take _____ Rapid Disolve Tab 1 hour prior to sexual activity.

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 in Men

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:** 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.

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

Print Name	Signature	Today's Date

1400 FM 528 Rd Suite A, Webster, TX 77598
281-886-7006

M SPA
FACE & BODY

Post-Insertion Instructions for Men

- Your insertion site has been covered with two layers of bandages. Remove the outer pressure bandage in 24hrs. It **MUST** be removed as soon as it gets wet. The inner layer is a steri-strip and the outer layer is a waterproof dressing. 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. You can continue for swelling if needed. 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 **5-7 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. You can do moderate upper body work and walking.
- 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 4 weeks after the insertion.
- Most men will need re-insertions of their pellets 4-6 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:

_____

_____

_____

_____

_____

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_____	_____	_____

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Male 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

☐ **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** ☐ 3mg ☐ 5mg ☐ 10mg ☐ 20mg ☐ 30mg ☐ 40mg ☐ 50mg **Take one pill by mouth daily at bedtime.**

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

☐ **Clomiphene Citrate** ☐ 1 mg daily for _____ days.

☐ **Oxytocin** ☐ 10IU disolve _____ under toungue one hour prior to sexual activity.

☐ **Arginine/Sildenafil** ☐ 70mg/363mg take _____ Rapid Disolve Tab 1 hour prior to sexual activity.

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

_____ _____

Print Name Date

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

_____

Signature

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Prostate Cancer Waiver for Testosterone Replacement

I voluntarily choose to undergo implantation of subcutaneous bio-identical testosterone pellet therapy even though I have a history of prostate cancer. I understand that such therapy is controversial and that many doctors believe that testosterone replacement in my case is contraindicated.

My treating Provider has informed me it is possible that taking testosterone could possibly cause cancer, or stimulate existing prostate cancer (including one that has not yet been detected). Accordingly, I am aware that prostate 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 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 **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.

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M SPA
FACE & BODY

Prostate Exam Waiver for Testosterone Replacement

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

For today's appointment, I have not provided you with a prostate exam report for 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. _____ **(initials of patient)**

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.

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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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