Blue Ridge Heart & Wellness

300 Hickman Road Suite 202
Charottesville, VA 22903

Tel: 434-296-9596
Fax: 434-296-9196

Female New Patient Package

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

Congratulations on taking interest in improving your overall health. In order to determine if you are a candidate for bio-identical hormone optimization, we need laboratory tests and your medical history. We will evaluate your information prior to your consultation to determine if these therapies can help you live a healthier life. **Please complete the following packet before your appointment.**

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

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Female Patient Questionnaire & History

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

How did you hear about us? :_____

Date of Birth:_____ Age:_____ Weight: ____ Occupation: _____

Home Address: _____

City:_____ State:_____ Zip: _____

Home Phone:_____ Cell Phone:_____ Work: _____

E-Mail Address:_____ May we contact you via E-Mail? ( ) **YES** ( ) **NO**

In Case of Emergency Contact:_____ Relationship: _____

Home Phone:_____ Cell Phone:_____ Work: _____

Primary Care Physician's Name:_____ Phone: _____

Address: _____
Address City State Zip

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

In the event we cannot contact you by the mean's you've provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are giving us permission to speak with your spouse or significant other about your treatment.

Spouse's Name:_____ Relationship: _____

Home Phone:_____ Cell Phone:_____ Work: _____

Social:

( ) I am sexually active.
( ) I want to be sexually active.
( ) I have completed my family.
( ) My sex has suffered.
( ) I 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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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
( ) Fibroids
( ) Post menopausal bleeding

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
( ) Hashimotos
( ) Arthritis.
( ) Depression/anxiety.
( ) Psychiatric disorder
( ) Cancer (type): _____Year: _____

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Hormone Replacement Fee Acknowledgment

Although more insurance companies are reimbursing patients for the BioTE® Medical 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.

New Patient Consult Fee (One-time fee, covered by most insurance,Cash Price)	**$200**
Female Hormone Pellet Insertion Fee (Frequency every 3-4 months)	**$400**
Male Hormone Pellet Insertion Fee (Frequency every 5-6 months)	**$700**

We accept the following forms of payment:

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

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

Cleveland Heartlab Contract Pricing Guide

Lab Draw & Specimen Handling (this charge + panel)	30.00
Labs Male Pre Pellett	128.14
Labs Female Pre Pellett	108.14
Labs Male Post Pellett	24.50
Labs Female Post Pellett	25.00
Labs Male Post Pellett Thyroid w/ TPO	62.00
Labs Female Post Pellett Thyroid w/ TPO	62.50
Labs Male Post Pellett w/ Thyroid	51.00
Labs Female Post Pellett w/ Thyroid	51.50
Labs Male/Female Thyroid Only	41.00
Labs Male/Female Thyroid w/ TPO	55.00
Labs Lipid Panel	9.00
Labs Vitamin D	21.00
Labs Progesterone	15.00
Labs HbA1C	10.00
Labs NT proBNP	32.00
Labs PSA Total	20.50
Labs Inflammation Planel	139.50
Labs Advanced Lipids	61.00
Labs Estrodial	20.00

We offer wholesale pricing through Cleveland Clinic for all of our lab testing. Above is a list of our contract pricing for most of the labs we offer. This is a pass through price we pay and pass on to our clients. These fees are significantly LOWER than your cost using your insurance in most cases. You are welcome to cost compare. Labs fees are due at the time of service.

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Health Assessment for Women

Name: _____ **Date:** _____

E-Mail: _____

Symptom	Severity N/A	Slight>>>>>>>>Moderate>>>>>>>>Severe									
Depressive mood	1	2	3	4	5	6	7	8	9	10
Fatigue	1	2	3	4	5	6	7	8	9	10
Memory Loss	1	2	3	4	5	6	7	8	9	10
Mental Confusion	1	2	3	4	5	6	7	8	9	10
Decreased libido/sex drive	1	2	3	4	5	6	7	8	9	10
Sleep problems	1	2	3	4	5	6	7	8	9	10
Irritability/Mood changes	1	2	3	4	5	6	7	8	9	10
Tension	1	2	3	4	5	6	7	8	9	10
Difficult to climax sexually	1	2	3	4	5	6	7	8	9	10
Bloating	1	2	3	4	5	6	7	8	9	10
Vaginal dryness	1	2	3	4	5	6	7	8	9	10
Hot flashes	1	2	3	4	5	6	7	8	9	10
Night sweats	1	2	3	4	5	6	7	8	9	10
Dry wrinkled skin	1	2	3	4	5	6	7	8	9	10
Hair is falling out	1	2	3	4	5	6	7	8	9	10
Weight gain/inability to lose	1	2	3	4	5	6	7	8	9	10
Breast tenderness	1	2	3	4	5	6	7	8	9	10
Cold all of the time	1	2	3	4	5	6	7	8	9	10
Joint pain	1	2	3	4	5	6	7	8	9	10

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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. All hormone optimization therapy, weight loss services and nutraceuticals are provided under **Blue Ridge Medical Weight Loss 47-2229673** which is not associated with any insurance companies. 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 insurancecompany.Anyfollowuplettersfromyourinsurancetouswill 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.

Name: _____Signature: _____Date:_____