



## Male 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.



### Male 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 means you've provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are giving us permission to speak with your spouse or significant other about your treatment.

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.
- ( ) I have used steroids in the past for athletic purposes.

#### Habits:

- ( ) I smoke cigarettes or cigars \_\_\_\_\_ a day.
- ( ) I drink alcoholic beverages \_\_\_\_\_ per week.
- ( ) I drink more than 10 alcoholic beverages a week.
- ( ) I use caffeine \_\_\_\_\_ a day.



## 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:

- |  |   |
|--|---|
| <input type="checkbox"/> High blood pressure.                  | <input type="checkbox"/> Testicular or prostate cancer.                             |
| <input type="checkbox"/> High cholesterol.                     | <input type="checkbox"/> Elevated PSA.  |
| <input type="checkbox"/> Heart Disease.                        | <input type="checkbox"/> Prostate enlargement.                                      |
| <input type="checkbox"/> Stroke and/or heart attack.           | <input type="checkbox"/> Trouble passing urine or take Flomax or Avodart.           |
| <input type="checkbox"/> Blood clot and/or a pulmonary emboli. | <input type="checkbox"/> Chronic liver disease (hepatitis, fatty liver, cirrhosis). |
| <input type="checkbox"/> Hemochromatosis.                      | <input type="checkbox"/> Diabetes.  |
| <input type="checkbox"/> Depression/anxiety.                   | <input type="checkbox"/> Thyroid disease.   |
| <input type="checkbox"/> Psychiatric Disorder.                 | <input type="checkbox"/> Arthritis.   |
| <input type="checkbox"/> Cancer (type): _____                  |   |
| Year: _____  |   |

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



## 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** **\$200.00**

(One-time fee, covered by most insurance, Cash Price)

**Female Hormone Pellet Insertion Fee** **\$400.00**

(Frequency every 3-4 months)

**Male Hormone Pellet Insertion Fee** **\$700.00**

(Frequency every 5-6 months)

**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

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





**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 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.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_