Female New Patient Package

The contents of this package are your first step to restore your vitality.
Please take time to read this carefully and answer all the questions as completely as possible.

Thank you for your interest in BioTE Medical®. In order to determine if you are a candidate for bio-identical testosterone pellets, we need laboratory and your history forms. We will evaluate your information prior to your consultation to determine if BioTE Medical® can help you live a healthier life. Please complete the following tasks before your appointment:

2 weeks or more before your scheduled consultation: Get your blood lab drawn at any Quest Laboratory/ or LabCorp Lab. If you are not insured or have a high deductible, call our office for self-pay blood draws. We request the tests listed below. It is your responsibility to find out if your insurance company will cover the cost, and which lab to go to. Please note that it can take up to two weeks for your lab results to be received by our office.

Your blood work panel MUST include the following tests:

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

Female Post Insertion Labs Needed at 4, 6 or 8 Weeks based on your practitioner’s choice:

___ FSH
___ Testosterone Total
___ CBC
___ Lipid Panel (Optional) (Must be a fasting blood draw to be accurate)
___ TSH, T4 Total, T3 Free, TPO (Needed only if you’ve been prescribed thyroid medication
___ Estradiol
Female Patient Questionnaire & History

Name: ___________________________  Today’s Date: ___________________________
  (Last) (First) (Middle)

Date of Birth: ____________________  Age: _______  Weight: _______  Occupation: ___________________________

Home Address: ___________________________

City: ___________________________  State: ___________  Zip: ___________

Home Phone: ___________________________  Cell Phone: ___________________________  Work: ___________________________

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

In Case of Emergency Contact: ___________________________  Relationship: ___________________________

Home Phone: ___________________________  Cell Phone: ___________________________  Work: ___________________________

Primary Care Physician’s Name: ___________________________  Phone: ___________________________

Address: ___________________________  Address ___________________________  City ___________________________  State ___________________________  Zip: ___________________________

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

In the event we cannot contact you by the 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.
Dr. Mackay
Vein & Circulation Specialist

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:
( ) 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: ____________
Female Testosterone and/or Estradiol Pellet Insertion Consent Form

Name: ___________________________ ___________________________ ___________________________ Today’s Date: ___________________________

Bio-identical hormone pellets are concentrated 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 made from soy 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; 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.


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: ___________________________
BHRT Checklist For Women

Name: ____________________________  Date: ____________________________
E-Mail: ____________________________

<table>
<thead>
<tr>
<th>Symptom (please check mark)</th>
<th>Never</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
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<tbody>
<tr>
<td>Depressive mood</td>
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<tr>
<td>Fatigue</td>
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<tr>
<td>Memory Loss</td>
<td></td>
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<tr>
<td>Mental confusion</td>
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<tr>
<td>Decreased sex drive/libido</td>
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<tr>
<td>Sleep problems</td>
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<tr>
<td>Mood changes/Irritability</td>
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<tr>
<td>Tension</td>
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<tr>
<td>Migraine/severe headaches</td>
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<tr>
<td>Difficult to climax sexually</td>
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<tr>
<td>Bloating</td>
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<tr>
<td>Weight gain</td>
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<tr>
<td>Breast tenderness</td>
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<tr>
<td>Vaginal dryness</td>
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<tr>
<td>Hot flashes</td>
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<tr>
<td>Night sweats</td>
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<tr>
<td>Dry and Wrinkled Skin</td>
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<tr>
<td>Hair is Falling Out</td>
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<tr>
<td>Cold all the time</td>
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<tr>
<td>Swelling all over the body</td>
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<tr>
<td>Joint pain</td>
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Family History

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<thead>
<tr>
<th></th>
<th>NO</th>
<th>YES</th>
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<tbody>
<tr>
<td>Heart Disease</td>
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<tr>
<td>Diabetes</td>
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<td>Osteoporosis</td>
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<td>Alzheimer’s Disease</td>
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<td>Breast Cancer</td>
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REQUEST TO RESTRICT DISCLOSURE TO HEALTH PLAN
{Authorized by Section 13405(a) of the HITECH Act}

I request that Edward G Mackay, (the “Practice”) not disclose my protected health information (PHI) to my health plan or other third party insurance carrier. Pursuant to Section 13405(a) of the HITECH Act, I understand I have the right to request restrictions on whether the Practice discloses my protected health information (PHI) with my health plan and the Practice is required to agree to my request unless the information is required to be disclosed to my health plan to comply with the law.

The records of the restricted services/items listed below (“Restricted Services/Items”) will not be released or billed to my health plan or other third party insurance carrier for the purposes of payment or health care operations. I understand I am financially responsible for these Restricted Services/Items and will pay out-of-pocket, in full, at the time of service in order for the Practice to accept this restriction request.

REQUESTED RESTRICTION:

Services/Items to be restricted: ____________________________

_____________________________________________________

Total Charge Amount (or estimated amount): $__________ per treatment/per month (circle one)

Other:

_____________________________________________________

(I understand that I am responsible for full charges when finalized)

Signed by: ________________________________ Date: __________

PRACTICE USE ONLY:

Obtained by: ________________________________ Date: __________

Print Patient Name: ____________________________

Print Patient Address: ____________________________
# Patient Service Agreement

## Consent for Services

By signing this agreement I give consent to the physicians, medical staff and employees of Edward G. Mackay, M.D. to provide health care services.

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Date of Birth</th>
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Photo Consent: For documentation purposes, Dr. Mackay requires before and after photographs of the treated area(s) in all medical records. Understanding that we will keep your identity confidential, I also grant permission for Edward G. Mackay, M.D., PA the use of my vein images to help promote healthy vein care for: Educational Purposes, Electronic Publishing, Print Publishing.

**SIGN:** Patient Signature: __________________________ Date: ____________

## Email / Text Auth

I hereby agree to allow Dr. Mackay to contact me by email or text with e-newsletters, special offers, appointment reminders and updates regarding health-related services provided by Dr. Mackay. I understand that Dr. Mackay will not share the information provided above with any outside parties.

_____ Yes  _____ No  Please provide email address above.

**SIGN:** Patient Signature: __________________________ Date: ____________

## Spider Vein Sclerotherapy / Compression Stockings

Most varicose vein procedures are covered by insurance. However, Sclerotherapy of Spider Veins is considered a cosmetic procedure and is NOT covered by any insurance company. The patient is responsible for payment and it is collected at the time of service for each treatment performed. If you are having surgical procedures done, sclerotherapy of spider veins is a completely separate service and not included in fees quoted for the varicose vein procedures.

Compression Stockings: If you are having a procedure performed that requires you to wear compression stockings, please understand that these are NOT covered by insurance. Although we recommend our brands for the best outcome, you may request a prescription to purchase stockings elsewhere. Also, many insurance companies have begun to require the use of compression stockings prior to approval of varicose vein treatment.

I have read and understand the above information and accept full financial responsibility.

**SIGN:** Patient Signature: __________________________ Date: ____________

## Authorization of Release of Medical Information

I authorize Edward G. Mackay, M.D. to release any medical information pertaining to my diagnosis and treatment to 1) any requesting physician or medical facility providing my medical care; 2) my insurance plan, employer (if employer-funded plan), Medicare, or other payer/provider of medical benefits which may or will pay for part of my medical expenses. I understand that release of this information may be required in order to obtain payment for medical expenses. This authorization applies to all information regarding my care.

**SIGN:** Patient Signature: __________________________ Date: ____________

I authorize discussion and release of my general medical condition and diagnosis (including treatment, payment and health care operations) with: □ Spouse  □ Other

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<thead>
<tr>
<th>Name:</th>
<th>Relationship:</th>
<th>Telephone:</th>
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</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Relationship:</td>
<td>Telephone:</td>
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</table>

## HIPAA Notice of Privacy Practices

We respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information in reference to your treatment, payment or health care operations, in order to provide health care that is in your best interest in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). My signature confirms that I am aware of my rights to privacy regarding my protected health information.

**SIGN:** Patient Signature: __________________________ Date: ____________
Financial Policy

The Doctor and staff at our office would like to welcome you to our practice. We strive to provide you with excellent medical care and our goal is to make your visits as convenient as possible.

**By signing below, you confirm that you have read and understand the following:**

- It is your responsibility to inform our office of any address, telephone, or insurance changes.
- Your account is to be kept current – accordingly, all self-pay or insurance co-payments, co-insurance, and deductibles will be collected at the time of service. Payable by check, Visa, MasterCard, Discover, American Express, or Care-Credit (if applicable).
- If you do not have your payment(s), your appointment may be rescheduled.
- You may be asked to schedule another appointment for issues other than the reason for your original appointment.
- A returned check will result in a $50.00 service charge and all future appointments being pre-paid will be required in the form of cash or credit card.
- You will only be sent a statement if your balance exceeds $5.00. Refunds will be issued if there are no pending insurance claims.
- There will be a $50.00 charge for the completion of paperwork (ex; Disability, FMLA, etc.)
- Any unpaid patient balances older than 30 days may be subject to 1.5% interest per month.
- There will be a 50.00 missed appointment fee charge for any appointment cancelled without 24 hours notice.
- For our patients submitting through their Insurance companies, because everyone’s plan is different, you will be charged the amount of the surgical supplies/equipment for cancelling a surgery with less than 48 business hours notice. The amount will vary depending on which surgery you were scheduled for.
- If your account is turned over to a collection agency, you will be responsible for any costs incurred in collection of said balance, which may include collection agency fees up to 35% of your outstanding balance, court costs, and attorney fees.

**If you have Health Insurance Coverage:**

We will submit your claims, however, we must emphasize that as a medical provider, our relationship is with you, not your insurance company. Although we attempt to verify your Specialist benefits with your insurance policy, please be advised this is only an estimate of your coverage based on the information given to us at the time of inquiry.

I understand that I am financially responsible for any and all charges rendered at the time of visit. If my insurer sends payment to me for services provided to me by Dr Mackay or his associates I understand it is my responsibility to forward that payment to Dr Mackay.

**By signing below, you confirm that you have read and understand the following:**

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified prior to your appointment.
- If your insurance policy requires a referral from your Primary Care Physician, it is your responsibility to obtain it and have it faxed to our office prior to your appointment.
- Not all services are a covered benefit with all insurance plans.
- It is your responsibility to be aware of what service(s) are being provided to you and if it is a covered benefit under your insurance policy.
- You are responsible for any non-covered charges not payable by your insurance policy.
- Although filing your insurance claims is a courtesy extended to you, all charges are always your responsibility from the date services are rendered.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, please do not hesitate to ask us. **We are here to help you.**

I have read and understand the above Financial Policy and agree to meet all financial obligations.

---

**SIGN:** X

**Patient Name (please print)**

**Patient Signature**

**Date**

**Responsible Party (please print)**

(If other than patient)

**Responsible Party Signature**

**Date**