Sutha Sachar, MD
3440 Lomita Blvd Suite 420 Torrance, CA 90505
424.250.9179

Female Initial Interest Form
Blood Work for Biote Procedure

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 bioidentical 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.

Today will consist of your consult to see if you are the right candidate and also bloodwork to assess your hormone status.

Your blood work panel will include the following tests:

Estradiol, FSH, Testosterone Total, TSH, Total T4, Free T3 T.P.O. (Thyroid Peroxidase), CBC, Complete Metabolic Panel, Vitamin D, 25-Hydroxy (Optional), Lipid Panel (Optional)

(Female Post Insertion Labs Needed at 4 weeks after and have a separate fee)

Name_____

Signature_____ **Date**_____

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REQUEST TO RESTRICT DISCLOSURE TO HEALTH PLAN
{Authorized by Section 13405(a) of the HITECH Act}

I request that Dr. Sutha Sachar 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 that 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:

_____

Signature:_____ Today's Date: _____

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FEMALE PATIENT QUESTIONNAIRE & HISTORY

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

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

Home Address: _____

City:_____State:_____Zip Code:_____

Cell Phone:_____Work: _____ Is it OK to text you ( ) YES ( ) NO

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. ( ) 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 including Latex? ( ) Yes ( ) No

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:
( ) SEIZURES
( ) 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:_____

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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	**$225 Includes Bloodwork**
Female Hormone Pellet Insertion Fee	**$495 includes 1 bottle of DIM**
Male Hormone Pellet Insertion Fee	**$865 includes 1 bottle of DIM**

This includes 1 bottle of DIM supplement, which will last 1 month for Men and 2 months for women.

Print Name:_____ Signature:_____

Today's Date: _____

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FEMALE PRE PELLET LABS QUESTIONNAIRE

PATIENT INFORMATION:

NAME:_____**DOB:**_____

TODAY'S DATE:_____

MEDICAL HISTORY:

STILL MENSTRATING: Y / N

HISTORY OF BREAST CANCER: Y / N **ENDOMETRIOSIS: Y / N**

HYSTERERECTOMY: Y / N **(IF YES, WERE OVARIES TAKEN OUT TOO? Y / N)**

CURRENTLY PREGNANT: Y / N **FIBROCYSTIC BREAST DISEASE: Y / N**

CURRENTLY ON HRT: Y / N (IF YES, SPECIFY_____**)**

POLYCYSTIC OVARIAN SYNDROME (PCOS): Y / N

HISTORY OF LEIOMYOMA OR ENDOMETRIAL POLYPS: Y / N

HASHIMOTO'S THYROIDITIS: Y / N **EPILEPSY: Y / N**

ANY HISTORY OF THYROID NODULES: Y / N **CURRENTLY ON THYROID MEDICATION: Y / N**

SYMPTOMS EXPERIENCED:

ACNE: Y / N **BREAST TENDERNESS: Y / N**

PREMENSTRUAL MIGRAINES: Y / N **FACIAL HAIR: Y / N**

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Commonly Asked Questions

Q. What is BioTE®? A. BioTE® is a Bio-Identical form of hormone therapy that seeks to return the hormone balance to youthful levels in men and women.

Q. How do I know if I am a candidate for pellets? A. Symptoms may vary widely from depression and anxiety to night sweats and sleeplessness for example. You will be given a lab slip to have blood work done which will determine your hormone levels. Once the doctor reviews and determines whether you are a candidate we will schedule an appointment for insertion.

Q. Do I have blood work done before each Treatment? A. No, only initially and 4-8 weeks later to set your dosing. You may have it done again if there are significant changes.

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.

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 practitioner will implant the pellets in the fat under the skin of the hip. A small incision is made in the hip. The pellets are inserted. No stitch is required.

Q. Does it matter if I'm on birth control? A. No, the doctor 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 are 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. This is an easy transition. The doctor 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 the Doctor.