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

MALE 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 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.

Please complete the following tasks before your appointment:

2 weeks or more before your scheduled procedure: Get your blood labs drawn at any CPL, Quest or LabCorp location. **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, Testosterone Total and Free, Total PSA ,TSH, Total T4, Free T3, T.P.O. (Thyroid Peroxidase), CBC, Complete Metabolic Panel, Vitamin D, 25-Hydroxy (Optional) Vitamin B12 (Optional), Lipid Panel (Optional)

Cash Price: $110

(Male Post Insertion Labs Needed at 4, 6 or 8 Weeks based on your practitioner's choice.)

❑ **PAID IN OFFICE TODAY**

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.

Signature:_____ Today's Date: _____

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MALE 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

Home Phone:_____ Cell Phone:_____Work: _____

Primary Care Physician's Name:_____ Phone:_____

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.

Significant Other/Spouse's Name:_____

Relationship:_____

Home Phone:_____ Cell Phone:_____Work: _____

( ) I DO NOT GIVE PERMISSION TO TALK TO ANYONE ELSE INCLUDING MY SPOUSE

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MEDICAL / SOCIAL HISTORY

Social: ( ) I am sexually active. ( ) I want to be sexually active.
( ) I have completed my family. ( ) I haven't been able to have an orgasm.

Habits: ( ) I smoke cigarettes or cigars per day. ( ) I drink alcoholic beverages per week.Quantity ____

Any known drug allergies including Latex? ( ) Yes ( ) No If yes, list _____

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:_____

Family History of any Cancers: _____

Medical Illnesses:
( ) SEIZURES
( ) High blood pressure.
( ) High cholesterol.
( ) Heart disease.
( ) Stroke and/or heart attack.
( ) Blood clot and/or a pulmonary emboli.
( ) Arrhythmia.
( ) Depression/anxiety.
( ) Testicular or prostate cancer.
( ) Elevated PSA
( ) Any form of Hepatitis or HIV.
( ) Lupus or other auto-immune disease.
( ) Fibromyalgia.
( ) Trouble passing urine
( ) Chronic liver disease (hepatitis, cirrhosis).
( ) Diabetes.
( ) Thyroid disease.
( ) Arthritis.
( ) Prostate Enlargement
( ) Cancer (type):_____ Year:_____
( ) Other

I understand that if I begin testosterone replacement with any testosterone treatment, including testos- terone 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 com- pletely 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 re- ported. I understand that higher than normal physiologic levels may be reached to create the necessary hormonal balance.

Signature:_____ Today's Date: _____

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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	**$250 (INCLUDES Blood work)**
Female Hormone Pellet Insertion Fee	**$495 includes DIM**
Male Hormone Pellet Insertion Fee	**$865 includes DIM**

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

We accept the following forms of payment:

Master Card, Visa, Discover, American Express, and Cash.

Print Name:_____ Signature:_____

Today's Date: _____

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MALE PRE PELLET LABS QUESTIONNAIRE

PATIENT INFORMATION:

NAME:_____ TODAY'S DATE:_____

THE PRIMARY REASON FOR HORMONE REPLACEMENT:

_____FATIGUE_____ POOR LIBIDO_____ POOR MUSCLE MASS _____WEIGHT GAIN_____

MEDICAL HISTORY (Needed for dosing):

ON 5A REDUCTASE (MEDICATION FOR HAIR LOSS, PROSTATE OR SLOW STREAM): Y / N

UROLOICAL WORK-UP & OK: Y / N

PROSTATE CANCER: Y / N

EPILEPSEY: Y / N

CURRENTLY ON THYROID MEDICATION: 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.