

Compass Hormone Health Female New Patient Paperwork

We are excited about your interest in hormone optimization through bioidentical hormone replacement therapy and nutraceutical use. In order to determine if you are a candidate for bio-identical testosterone and/or estrogen pellet treatment we will need you to fill out the following packet. Once completed, you can drop off or mail in your packet, or fax it to (603) 749-1006. We will evaluate your information upon receipt and call you to schedule a consultation to determine if can help you live a healthier and happier life.

Below is a list of the information we need in order to set up your initial appointment at Compass Family Health.

If you are already a CFH patient, these should already be on file.

- A Copy of Your Insurance Card front and back (We confirm eligibility prior to your appointment with Compass Family Health)
- Or** Check here if you are self-pay / have insurance we do not participate with
- Contact Information (ok to leave insurance #s off, but please do include guarantor's info if not the patient)
- Medical History (2 pages)
- Liability Waiver
- Permission to Share Information Form (If you do not want anyone listed please check none and sign)
- Financial Policy (please note new patients are agreeing to pay \$100 if you do not show for your appointment or cancel last minute)
- Member Administrative Fee Acknowledgement
- General Information (2 pages)
- HIPPA Agreement

Below is a list of the Compass Hormone Health forms and information we will need:

Visit 1: Hormone Optimization Discussion & Education (30 – 45 min with a Nurse or Provider)

- PCP referral *Only for HMO insurance policies (if Compass Family Health is not your pcp)
*Referral should be sent to Compass Family Health: Laura Hudson NPI 1659723286
Reason = Hormone management Diagnosis codes: Hormone Dysfunction E34.9 & HRT Z79.89
- Female Hormone Health History
- Female Patient Questionnaire & History
- Symptom Checklist for Women
- CFH > CHH Medical Record Release
- Recent (1-2 years) Mammogram **or** Mammogram Waiver
- Recent Pap-smear **or** Pap-smear Waiver
- Recent Bone Density Test Results

Visit 2: Review Labs, Create Algorithm Tx Plan and Discuss Forms Below (30 min with a Nurse or Provider)

- What might occur after pellet insertion
- You will need to have had your labs drawn at least **1-2 weeks prior to this visit** so we will have results available.

*It is your responsibility to find out if your insurance company will cover the cost. Of labs, and which lab your insurance prefers you go to. Please note that it can take up to two weeks for your lab results to be received by our office. If you are not insured or have a high deductible, call our office for self-pay blood draw forms, prices and instructions. (Estradiol, FSH, Testosterone Total, TSH, Free T4, Total T4, Free T3, Thyroid Peroxidase ab, CBC, CMP, Vitamin D3, Vitamin B12)

Visit 3: Initial Pellet Procedure *Note, this visit will be with Compass Hormone Health (self-pay 30min)

- Female Procedure Consent Form
- Mammogram Waiver and/or Pap-smear Waiver, if your testing is not up to date or available for review.

Visit 4: Post-Pellet 6 Week Follow-Up *Possible pellet boost if Testosterone levels aren't high enough (30-45min)

- You will need to have had your labs drawn 4-5 weeks after visit 3.

Visit 5: RePellet #1 *scheduled 3.5 months after visit #3

Subsequent "Re-pellet Appointments" will be scheduled every 3-4 months based on each patient's response to treatment.

Female Patient Questionnaire & Health 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: _____

Any known drug allergies: _____

Have you ever had any issues with local 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: _____ or Menopause Age: _____ Year: _____



Health History

Preventative Medical Care:

Date of Last Medical/GYN Exam: _____, any issues noted?

Date of Last Mammogram _____, any issues noted?

Date of Last Bone Density Scan _____, Results were: Normal, osteopenia, osteoporosis

Date of Last Pelvic ultrasound _____, Reason checked? _____, any issues noted?

Medical Illnesses: (Check if currently applicable)

Polycystic Ovary Syndrome (PCOS) Osteoporosis

High blood pressure Heart bypass / surgery

High cholesterol Arrhythmia Afib

Heart disease Stroke and/or heart attack.

Blood clot and/or a pulmonary emboli. Bleeding Disorder

Hepatitis HIV HPV (cervix / oral)

Lupus or other auto immune disease Arthritis

Trouble passing urine Taking Flomax or Avodart

Thyroid disease Fibromyalgia Diabetes.

Depression/anxiety Psychiatric disorder.

Cancer (type): _____ Year: _____ Outcome: _____

Any High-Risk Past GYN Medical/Surgical History: (Date if applicable)

Breast cancer Uterine cancer Ovarian cancer

Hysterectomy with removal of ovaries Hysterectomy only Removal of ovary(s) only L / R

Current Birth Control Method:

Menopause. Hysterectomy

Tubal ligation Vasectomy

Birth control pills IUD

Other: _____

Sexual: I am / am-not currently sexually active

I am not interested and that is ok

I want to be active

My sex life is suffering

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.

Family Medical History: (Note any significant illness)

Mom: _____

Dad: _____

Siblings: _____

Symptom Checklist For Women

Name: _____ DOB: _____ Date: _____

*Please place an "X" in the appropriate column for each symptom.

Symptoms	None	Mild	Moderate	Severe
Depressed Mood				
Anxiety				
Memory Loss				
Mental Confusion				
Decreased Libido				
Sleep Problems				
Mood Swing / Irritability				
Migraine Headaches				
Painful Sex				
Difficulty to Orgasm				
Bloating				
Weight Gain				
Breast Tenderness				
Vaginal Dryness				
Hot Flashes				
Night Sweats				
Dry or Wrinkled Skin				
Hair Loss / Thinning				
Cold all the Time				
Body Swelling				
Joint Pain				
Difficulty Sleeping				
Other:				
Other:				
Other:				

Additional Notes:

Hormone Pellet Placement Self-Pay Fee Acknowledgment

Although some of the providers at this practice are credentialed with insurances, they are not contracted with insurance companies when providing care at Compass Hormone Health. We have found some insurance companies are reimbursing patients for the Hormone Pellet Therapy, but there is no guarantee they will reimburse you for out of network procedures. We are happy to provide you with a receipt and letter of medical necessity, that you can send to your insurance company to file for reimbursement, if you would like to do so. Compass Hormone Health has set flat rates for the pellet procedure (which include your pellet cost) that you will be responsible for payment in full at the time of your procedure. We have no knowledge of your out-of-network policy coverage and will not bill insurance for the pellet procedure on your behalf.

Bloodwork: (An option for people with no insurance or poor lab coverage – you pay us at the time of the blood draw)

Self-pay Pre-pellet panel lab fee **\$135**
(Includes: CBC, CMP, B12, Vit D, TSH, TT4, FT3, TPO ab, Total Testosterone, FSH, Estradiol)

Self-pay Post-pellet-panel lab fee **\$100**
(Includes: CBC, Total Testosterone, FSH, Estradiol. *If on thyroid meds: TSH, Total T4, FT3, TPO ab)

Pellet Insertion: (This includes pellet-medication and procedure cost)

Female Hormone Pellet Insertion Fee **\$450**

Male Pellet Insertion Fee (T100 3mo plan) **\$575**

Male Hormone Pellet Insertion Fee (<2000mg) **\$750**

Male Pellet Insertion Fee (≥2000mg) **\$800**

We accept the following forms of payment:
Master Card, Visa, Discover, American Express, FSA cards and Cash

By Signing this form, I am indicating that I understand that Compass Hormone Health LLC is not affiliated with any insurance companies, and there for all pellet procedures are self-pay, with payment due at the time of treatment.

Print Name

Signature

Today's Date

Compass Hormone Health LLC & Compass Family Health LLC Protected Health Information Authorization to Share Medical Records

Patient Name: _____ **DOB:** _____

Other Last Names: _____ Phone: _____

Address: _____

This signed release will authorize **Compass Family Health** at 835 Central Ave Suite 200 Dover, NH 03820 and **Compass Hormone Health** -also doing business as **Compass Customized Health & Wellness** at 835 Central Ave Suite 226 Dover, NH 03820, to continuously disclose and exchange my protected health information between the two entities as needed to provide me with comprehensive care.

***Information to be Disclosed:** *(Please initial your preferred the option(s) below).*

_____ **Complete Medical Record** (This includes general health information and testing AS WELL AS applicable information related to mental health, drug or alcohol treatment, genetic testing, STD testing, HIV/AIDS, and psychotherapy notes.)

_____ **Complete Record** as Above, Except I **DO NOT** authorize the disclosure of:

_____ Information related to mental health

_____ Drug or alcohol treatment

_____ Genetic testing

_____ STD testing

_____ HIV/AIDS testing or care

_____ Psychotherapy Notes

I understand that the providers at Compass Family Health will continue to care for me and treat me, regardless of whether or not I sign this Authorization for Release of Records. I understand that this authorization may be subject to re-disclosure by the Receiving Health Care Agent for coordination of care.

I understand that I may revoke this Authorization at in time, by informing Compass Family Health in writing. Any revocation will not apply to disclosures that have already made. I understand that if this authorization is used to coordinate insurance coverage, I may not have the right to revoke it since insurance requires this information. I understand that I have a right to receive a copy of the information I am consenting to release.

This Authorization will expire twelve (36) months from the date this form is signed.

Printed Name

Date

Signature of Patient or Legal Representative

Relationship to Patient (if not patient)



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'm 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 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 is 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.