Westchase Medspa
Where aging is optional

6928 W. Linebaugh Ave. Suit 102, Tampa, FL 33625
(813) 749-7143
(813) 264-9262
www.westchasespa.com

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 bioidentical. 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.

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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 Total, TPO **(Needed only if you've been prescribed thyroid medication)**

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Female Patient Questionnaire & History

Name: (Last)	(First)	(Middle)	Todays' Date:
Date of Birth:	Age:	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:			
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.

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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:				
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.	☐ Chronic liver disease (hepatitis, fatty liver, cirrhosis).			
☐ Heart bypass.	☐ Diabetes.			
☐ High cholesterol.	☐ Thyroid disease.			
☐ Hypertension.	☐ Arthritis.			
☐ Heart Disease.	☐ Depression/anxiety.			
☐ Stroke and/or heart attack.	☐ Psychiatric Disorder.			
☐ Blood clot and/or a pulmonary emboli.	☐ Cancer (type):			
☐ Arrhythmia.	☐ Year:			
☐ Any form of Hepatitis or HIV.				
☐ Lupus or other auto immune disease.				
☐ Fibromyalgia.				
☐ Trouble passing urine or take Flomax or Avodart.				
Vital Statistics Weight:				

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BHRT Checklist For Women

Name:	Date:			
Email:				
Symptom (please check mark)	**Never**	**Mild**	**Moderate**	**Severe**
Depressive mood	☐	☐	☐	☐
Memory Loss	☐	☐	☐	☐
Mental confusion	☐	☐	☐	☐
Decreased sex drive/libido	☐	☐	☐	☐
Sleep problems	☐	☐	☐	☐
Mood changes/Irritability	☐	☐	☐	☐
Tension	☐	☐	☐	☐
Migraine/severe headaches	☐	☐	☐	☐
Difficult to climax sexually	☐	☐	☐	☐
Bloating	☐	☐	☐	☐
Weight gain	☐	☐	☐	☐
Breast tenderness	☐	☐	☐	☐
Vaginal dryness	☐	☐	☐	☐
Hot flashes	☐	☐	☐	☐
Night sweats	☐	☐	☐	☐
Dry and Wrinkled Skin	☐	☐	☐	☐
Hair is Falling Out	☐	☐	☐	☐
Cold all the time	☐	☐	☐	☐
Swelling all over the body	☐	☐	☐	☐
Joint pain	☐	☐	☐	☐
Other symptoms that concern you:				

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Female Testosterone and/or Estradiol Pellet Insertion Consent Form

Name: (Last) _____ (First) _____ (Middle) _____ 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 yam 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 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.**

Side effects may include: 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); safety of any of these hormones during pregnancy cannot be guaranteed. Notify your provider if you are pregnant, suspect that you are pregnant or are planning to become pregnant during this therapy, continuous exposure to testosterone during pregnancy may cause genital ambiguity; 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 and Hematocrit) should be done at least annually. This condition can be reversed simply by donating blood periodically.

BENEFITS OF TESTOSTERONE PELLETS INCLUDE: Increased libido, energy, and sense of well-being. Increased muscle mass and strength and stamina. Decreased frequency and severity of migraine headaches. Decrease in mood swings, anxiety and irritability. Decreased weight. Decrease in risk or severity of diabetes. Decreased risk of heart disease. Decreased risk of Alzheimer's and dementia.

I agree to immediately report to my practitioner's office any adverse reaction or problems that might be related to my therapy. Potential complications have been explained to me and I agree that I have received information regarding those risks, potential complications and benefits, and the nature of bio-identical and other treatments and have had all my questions answered. Furthermore, I have not been promised or guaranteed any specific benefits from the administration of bio-identical therapy. 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 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:_____

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Hormone Replacement Fee Acknowledgment

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 (aesthetic medicine) and therefore is not covered by health insurance in most cases.

This practice is not associated with any insurance companies, which means they are not obligated to pay for our services (blood work, consultations, insertions or pellets). 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.

New Patient Consult Fee **$150.00**

Female Hormone Pellet Insertion Fee **$350.00**

We accept the following forms of payment:
Master Card, Visa, Discover, American Express, Personal Checks and Cash.

Print Name:_____ Signature:_____ Today's Date:_____

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HIPAA Consent

I give Westchase Medspa my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care options like quality reviews. I give Westchase Medspa my consent to use or disclose my protected health information in order to obtain payment for services and/or product.

I have been informed that I may review Westchase Medspa's Notice Of Privacy Practices (for a more complete description on uses and disclosures) before signing this consent.

I understand that Westchase Medspa has the right to change their privacy practices and that I may obtain any revised notices at the clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that Westchase Medspa is not required to agree to the request. If Westchase Medspa agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Patient, parent or legal guardian:_____

Signature: _____ Date:_____

If signed by patient representative, state relationship to patient:_____

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