INSURANCE DISCLAIMER

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

Dr. Duchamp thru Bone And Hormone Wellness Center 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 any procedure, visit or medications 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.

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Name: _______________________________ Signature: _______________________________ Date: _____________
Bone and Hormone Wellness Center

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 (esthetic 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.

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New Patient Consult Fee
In Office........................................................................................................ $125.00

Male Hormone Pellet Insertion Fee................................................................. $625.00

Male Hormone Pellet Insertion Fee (over 2000mg).................................$725.00

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

WE NO LONGER ACCEPT CHECKS

___________________________________________  _____________________________________________________  ______________________
Print Name  Signature  Today’s Date
Male Patient Questionnaire & History

Name: ________________________________________

(First) (Middle) (Last)

Date of Birth: ______________ Age: ______ Weight ______________

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.
( ) I have used steroids in the past for athletic purposes.

Habits:

( ) I smoke cigarettes or cigars _________________________ a day.
( ) I drink alcoholic beverages _________________________ per week.
( ) I drink more than 10 alcoholic beverages a week.
( ) I use caffeine _________________________ a day.
Bone and Hormone Wellness Center

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: ___________________________________________________________

Other Pertinent Information: ___________________________________________________________

Medical Illnesses:

( ) High blood pressure. ( ) Testicular or prostate cancer.
( ) High cholesterol. ( ) Elevated PSA.
( ) Heart Disease. ( ) Prostate enlargement.
( ) Stroke and/or heart attack. ( ) Trouble passing urine or take Flomax or Avodart.
( ) Blood clot and/or a pulmonary emboli. ( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis).
( ) Hemochromatosis. ( ) Diabetes.
( ) Depression/anxiety. ( ) Thyroid disease.
( ) Psychiatric Disorder. ( ) Arthritis.
( ) Cancer (type): ____________________________ Year: _____________

I understand that if I begin testosterone replacement with any testosterone treatment, including testosterone 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 completely 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 reported. I understand that higher than normal physiologic levels may be reached to create the necessary hormonal balance.

_________________________________________  _____________________________________________________  __________
Print Name                                                                                      Signature                                      Today’s Date
# BHRT CHECKLIST FOR MEN

**Name:**

**Date:**

**Symptom (please check mark)**  
<table>
<thead>
<tr>
<th>Symptom</th>
<th>Never</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decline in general well being</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joint pain/muscle ache</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Excessive sweating</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleep problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Increased need for sleep</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Irritability</td>
<td></td>
<td></td>
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<tr>
<td>Nervousness</td>
<td></td>
<td></td>
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<tr>
<td>Anxiety</td>
<td></td>
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<tr>
<td>Depressed mood</td>
<td></td>
<td></td>
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<tr>
<td>Exhaustion/lacking vitality</td>
<td></td>
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<tr>
<td>Declining Mental Ability/Focus/Concentration</td>
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<tr>
<td>Feeling you have passed your peak</td>
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<tr>
<td>Feeling burned out/hit rock bottom</td>
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<tr>
<td>Decreased muscle strength</td>
<td></td>
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<tr>
<td>Weight Gain/Belly Fat/Inability to Lose Weight</td>
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<tr>
<td>Breast Development</td>
<td></td>
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<tr>
<td>Shrinking Testicles</td>
<td></td>
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<tr>
<td>Rapid Hair Loss</td>
<td></td>
<td></td>
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<tr>
<td>Decrease in beard growth</td>
<td></td>
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<td></td>
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<tr>
<td>New Migraine Headaches</td>
<td></td>
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<tr>
<td>Decreased desire/libido</td>
<td></td>
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<tr>
<td>Decreased morning erections</td>
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<tr>
<td>Decreased ability to perform sexually</td>
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<tr>
<td>Infrequent or Absent Ejaculations</td>
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<tr>
<td>No Results from E.D. Medications</td>
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</tr>
</tbody>
</table>

**Other symptoms that concern you:**

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