Youthful Expressions Med Spa
Khurram Khan, MD
Ruth Teague, FNP

Find out if BioTe Hormone Replacement Therapy is right for you!

STEP 1: Initial Consultation

Plan a consultation with one of our BioTe providers to discuss your symptoms, medical history and have your blood drawn to determine whether BioTe hormone therapy is an appropriate option for you. You will be provided with a BioTe folder with additional information and our BIOTE NEW PATIENT PACKET along with one of Dr. Donovitz's best selling books, *Age Healthier, Live Happier* or *Testosterone Matters…MORE*! Our staff will contact you once we receive your lab results to schedule your follow-up appointment.

We do not accept insurance for BioTe hormone replacement procedure visits. Patients may contact our staff to learn more about how to apply for the Care Credit payment option if needed.

STEP 2: Follow-up

Your follow up appointment typically lasts about one hour. We ask that you bring the patient intake packet that was provided to you during your consultation. Your BioTE provider will design a treatment protocol and discuss it with you before your pellets are inserted. The insertion procedure and aftercare instructions will also be discussed with you. The procedure itself typically takes only a few minutes. After your insertion you will be provided with written post care instructions and a bottle of DIM that you will be required to take daily. You will also be provided with instructions for your follow up lab work which should be performed 4-6 weeks after your procedure.
(Typically, 4 weeks for men and 6 weeks for women)

Plan a follow up office visit 1 week after your post-insertion lab work to review your results and symptomatic response to treatment, during this visit any necessary adjustments may be made to your treatment protocol. **Keep in mind that for very few patients the first treatment isn't always the best, this is the time that we are trying to determine what dosage works for you.**

When scheduling your appointments keep in mind that after your pellet insertion you will need to **avoid** "soaking" in water for at least 3 - 7 days.
This means no swimming, hot tubs, baths (you may shower), etc.

Youthful Expressions Med Spa
11511 FM 1960 Ste 102
Huffman, TX 77336

Phone (281) 324-1550 Fax (281) 324-1555

For additional questions call or e-mail:
stefanieluna@onlychoicecare.net & jessica@onlychoicecare.net

Certified BioTe Provider:
Ruth Teague, FNP-C

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Benefits of bioidentical hormone replacement therapy

For Both Men & Women

Improved energy levels
Improved muscle mass and tone
Improved exercise endurance
Improved fat loss
Improved memory and concentration
Improved sleep
Decreased joint and muscle pain
Improved bone density and strength
Improved cholesterol levels
Reduced risk of cardiovascular disease
Reduced risk of dementia
Improved sex drive and performance
Improved mood and motivation
Increased collagen and decreased skin wrinkles

Additional Benefits for Women

Eliminates night sweats
Eliminates hot flashes
Eliminates vaginal dryness & itching
Eliminates painful intercourse
Decreases belly fat

Who may NOT be a good candidate for therapy?

Please read the information outlined below BEFORE you consent to any lab work or schedule a consult with one of our providers.

1) **RECENT CANCER DIAGNOSIS:** Diagnosis of any form of cancer within the past 24 months may exclude a patient's eligibility to begin therapy. Patients must provide documentation that their cancer has been cured for 24 months or have a medical clearance letter from their oncologist stating they are safe to begin hormone replacement therapy.

2) **RECENT CARDIOVASCULAR EVENT**: Diagnosis of a heart attack, stroke, pulmonary embolism or other serious event such as cardiac or neurologic surgery within that past 24 months may exclude a patient's edibility to begin therapy.

3) **PREGNANCY**: Patients are not eligible for hormone replacement pellet therapy while they are pregnant.

4) **BREASTFEEDING:** Patients who are breastfeeding may not be eligible for therapy (this may be discussed with your provider).

5) **ELEVATED PSA TEST RESULT:** Patient's with a PSA (prostate specific antigen) result of 2.5 or greater must be evaluated by a urologist and receive a letter of medical clearance before they can begin hormone pellet therapy.

6) **HISTORY OF RECENT SEIZURE:** If you have a seizure disorder, epilepsy or have had a seizure within the past 24 months you may not be a candidate for hormone pellet therapy.

Patients that are planning to start a family or patients that are not finished completing their family should discuss other options with the provider

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Female Intake Form

Date _____

Name _____ DOB _____ Age _____

Mailing Address _____ C/S/Z _____

Primary Phone _____ Cell _____ Other _____

Marital Status (check one): ( ) Single ( ) Married ( ) Divorced ( ) Widow

Primary Care Physician _____ Phone _____

E-Mail _____ May we contact you via e-mail? Yes / No

May we send you appointment reminders via text? Yes / No Cell # _____

Were you referred to us? Yes / No If yes, by whom? _____

In Case of Emergency Contact:

Name _____ Phone _____ Relation _____

Name _____ Phone _____ Relation _____

Please list anyone allowed to call for records, receive reports/messages on your behalf, or that may pick up any such information for you. If you choose to not list anyone we will NOT speak to anyone, other than you, regarding your personal health information.

must update this form in the office. We will not accept verbel authorization

Name _____ Phone _____ Relation _____

Are you currently pregnant? Yes / No

Are you currently trying to become pregnant? Yes / No

Do you plan to become pregnant in the near future? Yes / No

Social and Medical History

Social:

( ) I'm sexually active. **OR ( )** I want to be sexually active. **( )** I do not want to be sexually active.
( ) I have completed my family. **OR ( )** I have NOT completed my family.
( ) My sex life has suffered.
( ) I have not been able to have an orgasm or it is very difficult.

If you are planning to start or expand your family soon, please talk to your provider about alternative options.

Birth Control Method:

- Birth control
- IUD
- Tubal Ligation
- Infertility
- Menopause
- Spouse Vasectomy
- Hysterectomy
- None
- Other _____

Habits:

Do you smoke or vape? **( )** Yes **( )** No. If yes, how much per day? _____
Do you consume alcohol? **( )** Yes **( )** No. If yes, how often? _____

Medications:

Are you currently taking any hormone medication(s)? Yes / No
If yes, what medication and how long have you been taking it?
_____

Please list all other medications you currently take

_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies:

Are you allergic to:

Soy	Yes / No	Lidocaine	Yes / No
Yams	Yes / No	Epinephrine	Yes / No
Betadine	Yes / No	Latex	Yes / No

List all known medication/other allergies:

_____

Social and Medical History (continued..)

Medical History

Breast Cancer	Yes / No	Stroke	Yes / No
Fibrocystic Breast	Yes / No	Seizure Disorder	Yes / No
Uterine Cancer	Yes / No	Irregular Periods	Yes / No
PCOS	Yes / No	Heavy Menstrual	Yes / No
Endometriosis	Yes / No	Acne	Yes / No
Thyroid Disease	Yes / No	HIV	Yes / No
Diabetes	Yes / No	Hepatitis	Yes / No
Ovarian Cancer	Yes / No		
Heart Disease	Yes / No		
Heart Attack	Yes / No		

Other Medical Conditions we should be aware of

_____ _____

_____ _____

_____ _____

Surgical History

Hysterectomy Yes / No Partial / Complete when? _____

Other Surgeries and dates:

_____ _____

_____ _____

_____ _____

_____ _____

HIPAA Acknowledgement Form

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Print Name _____ DOB _____

Signature _____ Date _____

Hormone Replacement Fee Acknowledgment & Insurance Disclaimer

Preventative medicine and bioidentical 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, nurses, nurse practitioners and/or physician assistants, insurance does not recognize bioidentical hormone replacement as necessary medicine BUT rather more like plastic surgery (aesthetic medicine). Therefore, bioidentical hormone replacement is not covered by health insurance in most cases.

Insurance companies are not obligated to pay for our services (consultations, insertions or pellets, or blood work done through our facility). We require payment at time of service and, if you choose, we will provide a form to send to your insurance company with a receipt showing that you paid out of pocket. However, we will NOT communicate in any way with your insurance company.

This form and your receipt are your responsibility and serve as evidence of your treatment. We will not call, write, pre-certify, appeal nor make any contact with your insurance company. If we receive a check from your insurance company, we will not cash it but will 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. Some of these accounts require that you pay in full ahead of time, however, and request reimbursement later with a receipt and letter. This is the best idea for those patients who have an HSA as an option in their medical coverage. It is your responsibility to request the receipt and paperwork to submit for reimbursement.

Office Visit Fee……..….$ 115.00
Pellet Insertion Fee……..……$ 350.00
DIM **(required)**…..……..…..$ 48.00

We accept the following forms of payment:
Credit card, Debit card, Cash, HSA's & Care Credit
NO CHECKS.

Patient Notice

We do NOT bill patients for blood work

We send ALL Lab tests to Path Group Laboratory. **ALL** labs are billed as "self pay" if no insurance information is provided at the time of service. We do not know what is and isn't covered by your insurance, be aware that most insurance will not cover hormone labs. If you disagree with any billing regarding your labs, you will need to call the laboratory. We can NOT make any changes regarding diagnosis codes, billing, etc. once it leaves our office. If your insurance has a preferred laboratory or you prefer to have your labs taken by your primary physician, you may ask for a lab order. Self pay patients may also ask for a lab order.

Alternative Choice: Ulta Lab offers affordable pricing for patients. Visit their website for more information. **(self-pay only)**
https://www.ultalabtests.com/shop

Name _____ DOB _____

Signature _____ Date _____

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Ruth Teague, FNP

Female Pellet Insertion Consent Form

My physician/practitioner has recommended bioidentical hormone therapy delivered by a pellet inserted under my skin for treatment of symptoms I am experiencing related to low hormone levels. The following information has been explained to me prior to receiving the recommended therapy.

OVERVIEW:

Bioidentical hormones are hormones that are biologically identical to that made in my own body. The levels of active estradiol and/or testosterone made by my body have decreased, and therapy using these hormones may have the same or similar effect(s) on my body as my own naturally produced hormones. The pellets are a delivery mechanism for estradiol and/or testosterone, and bioidentical hormone replacement therapy using pellets has been used since the 1930's. There are other formulations of estradiol and testosterone replacement available, and different methods can be used to deliver the therapy. There are no commercially available forms of testosterone, however, that are formulated specifically for use in women. The risks associated with pellet therapy are generally similar to other forms of replacement therapy using bioidentical hormones.

PELLET ACTIVE INGREDIENTS:

I understand that (please initial by the appropriate statement):

_____I am receiving pellets today that contain testosterone only.

_____I am receiving pellets today that contain estradiol and testosterone.

_____I am receiving pellets today that contain **testosterone and anastrozole.**

RISKS/COMPLICATIONS OF TESTOSTERONE:

- Risks associated with pellet insertion may include: bleeding from incision site, bruising, fever, infection, pain, swelling, pellet extrusion which may occur several weeks or months after insertion, reaction to local anesthetic and/or preservatives, allergy to adhesives from bandage(s), steri strips or other adhesive agents.
- Some individuals may experience one or more of the following complications with testosterone: acne, abnormal bleeding or a change in menstrual cycle (if patient has a uterus), anxiety, breast or nipple tenderness or swelling, insomnia, depression, mood swings, fluid and electrolyte disturbances, headaches, increase in body hair, fluid retention or swelling, mood swings or irritability, rash, redness, itching, lack of effect (typically from lack of absorption), transient increase in cholesterol, nausea, retention of sodium, chloride and/or potassium, weight gain or weight loss, thinning hair or female pattern baldness, hypersexuality (overactive libido) or decreased libido, overproduction of estrogen (called aromatization) or an increase in red blood cell formation or blood count (erythrocytosis). The latter can be diagnosed with a blood test called a complete blood count (CBC). This test should be done at least annually. Erythrocytosis can be reversed simply by donating blood periodically, but further workup or referral may be required if a more worrisome condition is suspected.

If you are planning to start or expand your family soon, please talk to your provider about other options.

RISKS/COMPLICATIONS OF ESTRADIOL (ONLY APPLICABLE IF RECEIVING ESTRADIOL IN THE PELLETS):

- The side-effects of estradiol are similar to those listed above for testosterone. Additionally, there is some risk, even when using bioidentical hormones, that estrogens may cause existing cases of some breast cancers to grow more rapidly. This risk may also apply to some undiagnosed forms of breast cancer.
- Using estrogen-alone (without progesterone) may increase the chance of getting cancer of the uterus. Endometrial sampling (biopsy) or surgery may be required if abnormal bleeding occurs.

****Please initial if you are postmenopausal, have a uterus, and are getting estradiol.**

_____I understand that I have a uterus and am receiving postmenopausal dosing of estradiol. I agree to take progesterone as directed by my health care provider while receiving estradiol.

Female Pellet Insertion Consent Form (continued…)

RISKS/COMPLICATIONS OF ANASTROZOLE (ONLY APPLICABLE IF RECEIVING ANASTROZOLE IN THE PELLETS):

Anastrozole is a type of medication called an aromatase inhibitor. Aromatase inhibitors limit or prevent the conversion of testosterone into estrogen. Aromatase inhibitors can be used for a variety of conditions but are most commonly used in patients with a history of estrogen receptor positive breast cancer.

Anastrozole should not be used in pregnant women and should be used with caution in women with pre-existing ischemic heart disease. Anastrozole in pellets should not be given to premenopausal women nor to women taking oral aromatase inhibitors (anastrozole or letrozole) or selective estrogen receptor modulators (tamoxifen or raloxifene).

The amount of anastrozole used in pellets is very low. The most common side-effects for women taking anastrozole are hot flashes, joint pain, and muscle pain. Because of the low dose in the pellet, these effects are not usually seen with this type of therapy, however.

CONSENT FOR TREATMENT:

- I agree to immediately report any adverse reactions or problems that may be related to my therapy to my physician or health care provider's office, so that it may be reported to the manufacturer. Potential complications have been explained to me, and I acknowledge that I have received and understand this information, including the possible risks and potential complications and the potential benefits.
- I also acknowledge that the nature of bioidentical therapy and other treatments have been explained to me, and I have had all my questions answered. I understand that follow-up blood testing will be necessary four (4) weeks after my initial pellet insertion and then at least one time annually thereafter. I also understand that although most patients will receive the correct dosage with the first insertion, some may require dose changes.
- I understand that my blood tests may reveal that my levels are not optimal which would mean I may need a higher or lower dose in the future. Furthermore, I have not been promised or guaranteed any specific benefits from the insertion of testosterone pellets.
- I accept these risks and benefits, and I consent to the insertion of testosterone pellets under my skin performed by my provider. This consent is ongoing for this and all future insertions in this facility until I am no longer a patient here, but I do understand that I can revoke my consent at any time. I have been informed that I may experience any of the complications to this procedure as described above.

By signing below you agree that you have read or have had this form read to you. You also agree that everything has been explained to you and you have had all of your questions answered by the nurse practitioner(s).

Print name _____ DOB _____

Signature _____ Date _____

Only Choice Urgent Care
K & J Care Unit, LLC

Khurram Khan, MD
Ruth Teague, FNP-C

Female Hormone Lab Order

Patient Name _____ DOB _____ Date _____

Diagnosis Code(s) _____

Lab Order:

☐ **Initial Labs:**

- ✓ Estradiol
- ✓ FSH
- ✓ Testosterone, Total
- ✓ TSH
- ✓ T4, Total
- ✓ T3, Free
- ✓ CBC W/ DIFF
- ✓ CMP

☐ **Post Insertion Labs:**

- ✓ FSH
- ✓ Estradiol
- ✓ Testosterone Total
- ✓ CBC W/ DIFF
- ✓ CMP

Additional

_____

Ordered by:

- Ruth Teague, FNP-C NPI 1215272166

Provider Signature _____ Date _____

Only Choice Urgent Care
11511 FM 1960 Ste 102
Huffman, TX 77336

Khurram Khan, MD NPI: 1336521897

Office Phone (281) 324-1550
Fax Results to (281) 324-1555

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POST-INSERTION INSTRUCTIONS FOR WOMEN

- Your insertion site has been covered with two layers of bandages. Remove the outer pressure bandage any time after 24 hours. It must be removed as soon as it gets wet. The inner layer (usually a steri strip) should be removed in 3 days.
- Do not take tub baths or get into a hot tub or swimming pool, etc. for 3-4 days. You may shower.
- No heavy lifting or major exercises for the incision area for the next 3-4 days, which includes running, elliptical, squats, lunges, etc.
- The sodium bicarbonate in the anesthetic may cause the site to swell for 1-3 days.
- The insertion site may be uncomfortable for up to2 to 3 weeks. If there is itching or redness you may take Benadryl for relief (25 to 50 mg orally every 6hours). Caution: this can cause drowsiness!
- You may experience bruising, swelling, and/or redness of the insertion site which may last from a few days up to 2 to 3 weeks.
- You may notice some pinkish or bloody discoloration of the outer bandage. This is normal.
- If you experience bleeding from the incision, apply firm pressure for 5 minutes.
- Please call if you have any bleeding not relieved with pressure (not oozing), as this is NOT normal.
- Please call if you have any discharge coming out of the insertion site, as this is NOT normal.
- **You may feel "jittery" after your procedure. This is caused from the mix of Lidocaine and Epinephrine that is used for numbing.**

➢ Remember to have your post-insertion blood work done 6 weeks after your FIRST insertion. If you are not feeling any better by 4 weeks, please call the office to have your labs drawn early.

➢ Most women will need re-insertion of their pellets 3-4 months after their initial insertion. If you experience symptoms prior to this, please call the office.

➢ **We ask that you schedule your next treatment in advance. We can not guarantee treatment for walk-ins.**

We require that patients on Biote Hormone Replacement take DIM 150mg daily.
You can purchase this from our office for $48.

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WHAT MIGHT OCCUR AFTER A PELLET INSERTION

A significant hormonal transition will occur in the first four weeks after the insertion of your hormone pellets. Therefore, certain changes might develop that can be bothersome.

• **INFECTION** Is possible with any type of procedure. Infection is uncommon with pellet insertion and occurs in <0.5 to 1%. If redness appears and seems to worsen (rather than improve), is associated with severe heat and/or pus, please contact the office. Warm compresses are helpful, but a prescription antibiotic may also be needed.

• **PELLET EXTRUSION:** Pellet extrusion is uncommon and occurs in <5% of procedures. If the wound becomes sore again after it has healed, begins to ooze or bleed or has a blister-type appearance, please contact the office. Warm compresses may help soothe discomfort.

• **ITCHING or REDNESS:** Itching or redness in the area of the incision and pellet placement is common. If you have a reaction to the tape, please apply hydrocortisone 2-3 times per day to the rash. If redness becomes firm or starts to spread after the first few days, you will need to contact the office.

• **FLUID RETENTION/WEIGHT GAIN:** Testosterone stimulates the muscle to grow and retain water which may result in a weight change of two to five pounds. This is only temporary. This happens frequently with the first insertion, and especially during hot, humid weather conditions.

• **SWELLING of the HANDS & FEET:** This is common in hot and humid weather. It may be treated by drinking lots of water, reducing your salt intake, or by taking a mild diuretic, which the office can prescribe.

• **BREAST TENDERNESS or SWELLING:** This usually occurs most commonly in the first round of pellets but does not usually continue thereafter. DIM 1 capsule daily is helpful in preventing this, but the dose may be increased to 2-3 daily, if needed. Evening primrose oil (available in our office) is helpful as is Iodine+ if this occurs.

• **MOOD SWINGS/IRRITABILITY/ANXIETY:** These may occur if you were quite deficient in hormones. These symptoms usually improve as hormone levels improve. 5HTP can be helpful for this temporary symptom and can be purchased at many health food stores.

• **ELEVATED RED CELL COUNT (most common in men):** Testosterone may stimulate growth in the bone marrow of the red blood cells. This condition is called erythrocytosis. Erythrocytosis may also occur in some patients independent of any treatments or medications. If your blood count goes too high, you may be asked to see a blood specialist called a hematologist to make sure there is nothing worrisome found. If there is no cause, the testosterone dose may have to be decreased.

• **HAIR LOSS:** Is rarely due to pellets but can occur in some patients who convert testosterone to DHT. Dosage adjustment generally reduces or eliminates the problem. Prescription medications may be necessary in rare cases. Workup for other causes may also be needed.

• **FACIAL BREAKOUT:** Some pimples may arise if the testosterone levels are either too low or rise rapidly. This lasts a short period of time and can be handled with a good face cleansing routine, astringents and toner. If these solutions do not help, please call the office for suggestions and possibly prescriptions.

• **UTERINE SPOTTING/BLEEDING/IRREGULAR PERIODS:** This may occur in the first few months after an insertion, especially if you have been prescribed progesterone and are not taking properly: i.e. missing doses, or not taking a high enough dose. Please notify the office if this occurs. Bleeding is not necessarily an indication of a significant uterine problem.

• **HAIR GROWTH:** Testosterone may stimulate some growth of hair on your chin, chest, nipples and/or lower abdomen. This tends to be hereditary. Fine, vellous hairs or "peach fuzz" often occurs but is not thick nor coarse. You may also have to shave your legs and arms more often. Dosage adjustment generally reduces or eliminates the problem.