

## Hormone Replacement Therapy Questionnaire

• **Personal Data:**

Name \_\_\_\_\_ DOB \_\_\_\_\_  
 Gender  Female  Male Age \_\_\_\_\_ Last Physical/Blood Test \_\_\_\_\_  
 Primary Physician's Name: \_\_\_\_\_ Office Number: \_\_\_\_\_

• **Personal Medical History:**

**Do you or have you ever had any of the following?**

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Bacterial/viral/fungal infection	<input type="checkbox"/> Celiac Disease
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Blood Disease
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Headaches	<input type="checkbox"/> Alzheimer's Disease
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Depression	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Neurological Disorders
<input type="checkbox"/> Thyroid Disorders	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Altered Mood Changes
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Gastric Reflux	<input type="checkbox"/> Skin Disorders
<input type="checkbox"/> Asthma/COPD	<input type="checkbox"/> IBS/Ulcerative colitis/Crohn's	<input type="checkbox"/> Autoimmune Disease
<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Allergies (pet, seasonal, food)	<input type="checkbox"/> Anemia

Do you smoke?  YES  NO If yes, how many packs a day \_\_\_\_\_  
 Do you drink alcohol?  YES  NO If yes, type & weekly intake \_\_\_\_\_

**For women**

Age of first menstruation: \_\_\_\_\_ First day of last menstrual period \_\_\_\_\_  
 How many days your period last? \_\_\_\_\_ How often do you get your period? \_\_\_\_\_  
 Are you pregnant or planning to get pregnant?  YES  NO  
 Have you had a mammogram or Pap smear?  YES  NO  
 Are you currently using contraception?  YES  NO Name \_\_\_\_\_  
 Date of last: Mammogram \_\_\_\_\_ Pap smear \_\_\_\_\_ Bone Density \_\_\_\_\_

**Medication, Vitamins & Supplements List:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Allergies:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Surgical History:** Please list any surgical procedures and the year \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- **Family Medical History:** Has anyone in your family had any of the following?  
Please specify relationship.

<input type="checkbox"/>	Heart Disease	Relationship _____
<input type="checkbox"/>	High Blood Pressure	Relationship _____
<input type="checkbox"/>	Cancer (type)	Relationship _____
<input type="checkbox"/>	Stroke	Relationship _____
<input type="checkbox"/>	Diabetes	Relationship _____
<input type="checkbox"/>	Renal Disease	Relationship _____
<input type="checkbox"/>	Osteoporosis	Relationship _____
<input type="checkbox"/>	High Cholesterol	Relationship _____
<input type="checkbox"/>	Other	Relationship _____

- **Hormone Therapy History:**

Are you currently or have had Hormonal Replacement therapy?  Yes  No

If yes, what type of hormones you have replaced or balanced?

- |                                   |  |                                    |                                       |
|-----------------------------------|--|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Estrogen | <input type="checkbox"/> Progesterone  | <input type="checkbox"/> DHEA-S    | <input type="checkbox"/> Testosterone |
| <input type="checkbox"/> Thyroid  | <input type="checkbox"/> Cortisol  | <input type="checkbox"/> Melatonin | <input type="checkbox"/> Pregnenolone |
| <input type="checkbox"/> Cortisol | <input type="checkbox"/> Neurotransmitters IgF-1 (a marker for human growth hormone) |                                    |                                       |

- **Present Symptoms:**

As you have aged, have you experienced any of the following?

<input type="checkbox"/> Decreasing muscle mass or flabbiness	<input type="checkbox"/> Reduced strength
<input type="checkbox"/> Increased stiffness	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Decreased endurance	<input type="checkbox"/> Significant weight loss or weight gain
<input type="checkbox"/> Significant weight gain	<input type="checkbox"/> Increased body fat
<input type="checkbox"/> Fluctuations in body temperature	<input type="checkbox"/> Sensitivity to cold or heat
<input type="checkbox"/> Night sweats	<input type="checkbox"/> Mood swings
<input type="checkbox"/> Irritability	<input type="checkbox"/> Dryer or thinning skin and hair
<input type="checkbox"/> Poor sleep	<input type="checkbox"/> Sleep difficulties
<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Mood changes
<input type="checkbox"/> Increased anger or irritability	<input type="checkbox"/> Unexplained depression or anxiety
<input type="checkbox"/> Alcohol intolerance	<input type="checkbox"/> Stress

- **Are you experiencing any of the following symptoms? (Neurotransmitters)**

<input type="checkbox"/> Sadness	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Decreased ability to focus	<input type="checkbox"/> Intestinal pain or cramping
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Constipation
<input type="checkbox"/> Feeling panicked/frightened	<input type="checkbox"/> Feeling hyper or revved up
<input type="checkbox"/> Feeling fidgety or restless	<input type="checkbox"/> Feeling worthless or hopeless
<input type="checkbox"/> Feeling unrefreshed or tired	<input type="checkbox"/> Lack of energy or endurance
<input type="checkbox"/> Difficulty falling asleep	<input type="checkbox"/> Decreased interest in daily activities
<input type="checkbox"/> Difficulty staying asleep	<input type="checkbox"/> Forgetfulness or poor memory
<input type="checkbox"/> Gas or bloating	<input type="checkbox"/> Low sexual desire

- Check which of these symptoms are troublesome and have persisted over time

**Hormones Women:**

<input type="checkbox"/> Hot flashes	<input type="checkbox"/> Night sweats	<input type="checkbox"/> Vaginal dryness
<input type="checkbox"/> Urinary incontinence	<input type="checkbox"/> Irritability	<input type="checkbox"/> Sleep disturbances
<input type="checkbox"/> Painful intercourse	<input type="checkbox"/> Decreased libido	<input type="checkbox"/> Mood changes
<input type="checkbox"/> Foggy thinking	<input type="checkbox"/> Weight gain	<input type="checkbox"/> Irregular periods
<input type="checkbox"/> Cold body temperature	<input type="checkbox"/> Nervous	<input type="checkbox"/> Depression
<input type="checkbox"/> Decreased bone density	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Skin dryness
<input type="checkbox"/> Thinning hair	<input type="checkbox"/> Decreased work performance	
<input type="checkbox"/> Aches/Pains	<input type="checkbox"/> Decreased mental sharpness	
<input type="checkbox"/> Frequent somnolence	<input type="checkbox"/> Decreased energy	
<input type="checkbox"/> Decreased height	<input type="checkbox"/> Urine frequency/urgency	

**Hormones Men:**

Date of last: Prostate exam \_\_\_\_\_ PSA test \_\_\_\_\_

<input type="checkbox"/> Decreased sex drive	<input type="checkbox"/> Irritability	<input type="checkbox"/> Loss of muscle mass
<input type="checkbox"/> Decreased energy/fatigue	<input type="checkbox"/> Decreased height	<input type="checkbox"/> Sleep disturbances
<input type="checkbox"/> Nervous	<input type="checkbox"/> Breast enlargement	<input type="checkbox"/> Mood changes
<input type="checkbox"/> Foggy thinking	<input type="checkbox"/> Depression	<input type="checkbox"/> Sadness/Unhappiness
<input type="checkbox"/> Cold body temperature	<input type="checkbox"/> Erection difficulty	<input type="checkbox"/> Hair loss/thinning
<input type="checkbox"/> Weight gain	<input type="checkbox"/> Prostate enlargement	
<input type="checkbox"/> Aches/Pains	<input type="checkbox"/> Decreased work performance	
<input type="checkbox"/> Frequent somnolence	<input type="checkbox"/> Weight gain (mid-portion)	
<input type="checkbox"/> Decreased mental sharpness		

- Are you experiencing any of the following symptoms? (Human Growth Hormone)

<input type="checkbox"/> Memory problems	<input type="checkbox"/> Lack of positive well-being
<input type="checkbox"/> Weight gain (mid-portion)	<input type="checkbox"/> Decreased lean body mass
<input type="checkbox"/> Increased body fat	<input type="checkbox"/> Decreased bone density
<input type="checkbox"/> Decreased energy	<input type="checkbox"/> Decreased strength
<input type="checkbox"/> Unexplained sadness	<input type="checkbox"/> Low stamina

In your own words, what you would like to get from this program? \_\_\_\_\_

Patient Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

MD/NP Signature \_\_\_\_\_ Date \_\_\_\_\_

**To be completed by office staff**

Mammogram	Exam received	<input type="checkbox"/> YES <input type="checkbox"/> NO
Pap Smear	Exam received	<input type="checkbox"/> YES <input type="checkbox"/> NO
Bone Density	Exam received	<input type="checkbox"/> YES <input type="checkbox"/> NO



## **INFORMED CONSENT FOR HORMONAL REPLACEMENT THERAPY**

\_\_\_\_\_ (Patient) and \_\_\_\_\_ (Physician) hereby enter into this agreement for provision of medical services specified herein (“services”). Wherefore, in exchange for consideration, the receipt and sufficiency of which the parties hereby acknowledge the PATIENT and PHYSICIAN agree as follows:

1. \_\_\_\_\_ and its PHYSICIANS are responsible for the evaluation and prescription of hormone replacement therapy, indicated by the history, physical examination and laboratory parameters. All costs including physician services and laboratory if indicated are to be paid in full by PATIENT, to the PHYSICIAN, at the time services are rendered.
2. The PATIENT acknowledges and agrees that this agreement has been entered into before the PHYSICIAN and the PHYSICIAN has provided the services specified herein to the PATIENT.
3. The PATIENT acknowledges and agrees that this agreement has not been entered into at the time when the PATIENT is facing an emergency or an urgent health care situation.
4. The services to be provided to the PATIENT are: evaluation of medical history, performing diagnostic tests and providing anti-aging and hormone-balancing replacement therapy.
5. The PATIENT agrees to be responsible for the SERVICES. Our office does not accept insurance plan payments. We are a fee-for-service office. Patients are responsible for payment in full for services rendered to them. Methods of payment include cash and major credit cards (Visa, MasterCard and Discover). Payment is due at the time of the service.
6. Hormone replacement therapy is medical treatment; even though some insurance companies have not yet accepted this position. At this point in time, PHYSICIANS cannot assure the PATIENT that their insurance company will reimburse for preventative care or anti-aging or hormone-balancing replacement therapy. An appropriated statement of payment will be provided, including a list of charges and descriptions of the office visit for the levels of service provided. The codes used for these purposes may or may not correspond to the codes used by the insurance companies. Changes to the codes will not be made for the use of any insurance company. Insurance may reimburse patients for expenses related to some of the medical services. Reimbursement will not be made from the insurance company to the physician. Please note that The Aesthetic & Wellness Center will not present a bill to any insurance company for services provided or related charges.
7. The PATIENT agrees to check with insurance plan for the correct self-billing instructions and appropriate forms. It is advised to make copies of all forms prior to submitting insurance claims. We are not responsible for denials, non-payments by your insurance company, or filing appeals to insurance companies.
8. The PATIENT acknowledges that health insurance plans such as MEDICARE or MEDICAID will not provide reimbursement for the SERVICES and that no fee limits will apply to the amounts PHYSICIANS charge for their SERVICES. If you are covered by Medicare, then you must complete and sign ABN form prior to participating in the program.



9. The PATIENT acknowledges that some insurance companies may not cover prescriptions called on to a compounding pharmacy therefore the compounding pharmacy will call you directly for a method of payment prior to shipping.

10. The PATIENT acknowledges that some insurance companies may not cover the cost for some of their hormonal testing required. The PATIENT will be responsible for the payment of the blood tests not covered. If PATIENT does not have insurance, we have negotiated with the lab a reduced price starting at \$275 and up. No refund can be given once lab test have been performed. Once hormonal imbalance has been stabilized, patients must have bi-annual blood work and follow-up visits in person for the prescriptions to be filled. Lab results will be reviewed and discussed with you during your follow-up visit.

11. The PATIENT acknowledges that prescription refills are called in within 72 hours of the request. After stabilization of hormonal imbalance, prescriptions will be provided for a three month period. Patients, who have been seen bi-annually, may need to be reevaluated before a prescription is called in. Prescriptions for hormones like estrogen, progesterone and testosterone and average \$40 or more each per month per hormone.

12. The PATIENT acknowledges that PATIENT has the right to have services provided by other PHYSICIANS, for whom payment may be made under health insurance plans or MEDICARE. We do not assume the responsibility for treatment of major medical illnesses that you are currently being cared for by your primary physician or other care provider. Please continue treatment with your primary care OB/GYN for routine medical problems. We do not provide or complete disability or physical exams form for patients who desire there services. Your primary care physician must complete these forms.

13. The Health Insurance and Reform Act of 1997 allows the Federal Government to investigate what they may determine is "health insurance fraud" or any medical treatment not deemed "medically necessary" by Federal Government. Even though the use of human growth hormone in adults has been approved by the Food and Drug Administration, it has not been recognized by the Federal Government as "medically necessary" and, therefore, could be interpreted as fraudulent.

14. I have read and fully understand the information above related to the insurance and participation in The Aesthetic and Wellness Center services. I have also had the opportunity to ask questions regarding the information included above. I am aware that I will receive an appropriate receipt of payment for my personal use. I understand the specifics of this receipt and limitations as described in this document. I accept these specific policies as written. The above information is true to the best of my knowledge. I am satisfied with the information provided during my consultation. I understand the nature of this procedure and treatment, and all my questions to this date have been answered completely. I have read and understand the consent above. I hereby affix my signature to this authorization for this proposed long-term treatment. I have been given and copy of this consent form.

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Patient Signature

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Date



## **Consent for the Evaluation and Treatment for Hormone Balancing Therapy**

I, \_\_\_\_\_ authorize and give consent to Inda Mowett, M.D. and other physicians, associates and any other healthcare personnel for the evaluation and treatment of my aging process by the administration of hormones, other pharmaceutical interventional therapies and dietary supplements, and any other therapeutic agents in this document. The goal and possible benefits of this therapy are to try and stop, slow and/or reverse my aging process, through hormonal balancing, control of oxidative stress, and other clinically significant therapeutic agents.

I have been fully informed, and I am satisfied with my understanding, that this treatment may be viewed by the medical community as new, controversial, and unnecessary by the Food and Drug Administration, given the present state of knowledge regarding the human aging process.

### **Off Label Use**

\_\_\_\_\_ I have been completely informed, and I am totally satisfied with my understanding, that the proposed treatment may involve the use of prescription medications such as hormones that have been approved by the Food and Drug Administration (FDA) for medical conditions, other than the slowing, stopping and/or reversing of the aging process.

### **General Risks**

\_\_\_\_\_ I understand and am completely satisfied that the general risks of this proposed treatment and therapy include, but are not limited to, fluid retention or edema, hair loss, hair growth, enlarged breasts, gastrointestinal symptoms, drowsiness, acne, irritability and mood changes. If treatment is provided as an injection, it is possible you may experience soreness or pain and possible infection at the injection site.

I understand and am fully satisfied with the knowledge, that there are risks (both known and unknown) to any medical procedure and treatment; including the proposed therapy for slowing or reversing the aging process, and that it is not even possible to guarantee or give assurance of a successful result. I freely acknowledge and accept these known and unknown general risks.

### **Patient Compliance - Informed Consent Agreement**

\_\_\_\_\_ I understand and agree to follow the proposed treatment and therapy as prescribed without any deviation, including the fact that I may be responsible for injecting, taking by mouth, applying to my skin, or administering the hormone(s) or other designated therapies that may be prescribed to me possibly more than once daily. I consent to periodically have my blood drawn or urine specimens obtained for laboratory monitoring and analysis. I also agree to take the dietary supplements, hormone preparations and other designated therapies on the schedule that has been individually designed for me, as prescribed specifically in detail. I have completely and faithfully disclosed my complete medical history, all prescription and supplements that I am currently taking or plan to take during my treatment, as well as any other over-the-counter medications, recreational drugs or social substances, herbs, extracts, and other dietary supplements. I agree to completely follow the recommendations regarding the continuation or discontinuation of these preparations. In the future, I will receive prior authorization in advance from you, before stopping any of the



prescribed therapeutic regimens or taking any additional preparations that are not suggested or prescribed by Dr. Mowett.

I also understand that the use of "social substances" such as tobacco, "street drugs," and alcohol and other type of otherwise non-described "social substances" may affect my therapy in a significantly adverse manner.

### **Diagnosis**

\_\_\_\_\_ I fully understand that the medical diagnosis of "deficiency and insufficiency" do not apply to my case because such diagnosis may require tests to establish much lower levels, and as such my levels could be considered normal under that standard.

### **Specific Risks**

\_\_\_\_\_ The following are examples of some of the possible specific risks or adverse reactions reported for hormone therapy that may be prescribed for me. Some of these risks and or adverse reactions are for prescription hormones derived from the official Food and Drug Administration (FDA) labeling requirements for these drugs at therapeutic levels in the blood. Therapeutic blood or urine levels of medications are concentrations that show a therapeutic clinical effect when prescribed at designated pharmacological dose. Our goal is to achieve physiologic levels that are set of a 20-year-old person and would be within the "normal" or "average" blood concentrations of that age group. At physiological blood levels, there are not expected to be any significant risks or adverse reactions as long as full medical disclosure is achieved from the patient during the total time of therapy.

I certify that I will notify immediately of any and all possible symptoms, signs, or possible reactions to my therapy.

Your physician may prescribe the following hormones, other medications or nutraceuticals, as follows:

### **Prescription and Non-Prescription Hormone/Other Suggested or Prescribed Therapies:**

- **Estrogen**

\_\_\_\_\_ A prescription hormone, given as tablets or transdermal cream. Dr. Mowett wants you to be aware of potential risks. HRT has been associated most frequently with the following medical problems: breast tenderness, fluid retention, vaginal bleeding, acne, headaches, risk of gallstones, enlarge fibroids, thrombosis and irritability. When used without Progesterone in women who still have their uterus, the risk cancer of the uterus and breast cancer could increase. To reduce the risk, Dr. Mowett will prescribe Progesterone.

No long-term studies on the use of bio-identical hormone replacement therapy are available. Risks are based on studies of synthetic conjugated estrogens.

- **Progesterone**

\_\_\_\_\_ A prescription hormone, given by sublingual tablets, capsules or cream. Most common side effects are breast or nipple tenderness, fluid retention, acne, decreased sexual drive, breakthrough bleeding, mood changes, increased nervousness, gallbladder disease, breast cancer and cardiovascular disease. Recent research suggests a relationship between Progestin and Cancer.

Progestin is a synthetic Progesterone and is not the same as natural Progesterone. There has been no research to support the relationship between natural Progesterone and cancer.

- Testosterone

\_\_\_\_\_A prescription hormone, given by transdermal cream or pellets. Most common side effects are acne, clotting disorders, deepening of the voice, an enlarged clitoris, hair loss, hair growth on the face, changes in sex drive (normally an increase in sex drive), anger or hostility, shrinking in the size of the testicles and reduction in sperm production. Testosterone can increase hemoglobin and hematocrit, increasing the risk of clotting. For this reason, a CBC is repeated on follow-up lab work.

- Testosterone can change anti-coagulant therapy, so those monitoring their INR will need to check this more regularly. Testosterone may decrease blood sugar levels lowering insulin and anti-diabetic oral agents. Adjustments may need to be made in these medications.

- Thyroid Hormone

\_\_\_\_\_A prescription hormone taken by mouth. Risks/adverse reactions include palpitations, sleep disturbances, excitability, and increased metabolism.

- Dehydroepiandrosterone - DHEA

\_\_\_\_\_Given by mouth and classified as a dietary supplement. In excess amounts, adverse reactions include facial hair and acne in women, and prostate enlargement in men.

- Human Growth Hormone (HGH) - Somatotropin

\_\_\_\_\_A prescription hormone given by hypodermic injection or transdermal infusion. Adverse reactions at therapeutic levels include transient high blood sugar (hyperglycemia), development of antibodies to HGH, localized joint pain and fluid retention. This drug should not be used in patients with a known cancer. These side effects are dose-related and are usually eliminated by adjusting the dosage.

- Melatonin

\_\_\_\_\_A dietary supplement given by mouth given to regulate sleep cycle. The major reported adverse side effects are drowsiness, headache, fatigue, nightmares and exaggerated depressive symptoms. Melatonin has been commonly used to alleviate jet lag.

### **Other Risks**

\_\_\_\_\_It is not humanely possible to list all the possible risks and complication and the variations that may arise in any medical procedure such as hormonal balancing in the individual examples above. Each patient may react differently to treatment. If you experience any other symptom not listed in this document, report immediately to Dr. Mowett or staff.



### **Alternative Treatments**

\_\_\_\_\_ I have been completely informed via informed consent of the existing law. I am totally and completely satisfied with my understanding of the reasonable alternatives to this procedure which include:

- Leaving the hormone levels as they are - and doing nothing
- Treating age -related diseases as they appear clinically and symptomatically.

### **Other Alternatives**

\_\_\_\_\_ Although you have decided upon the proposed treatment to try to stop, slow or reverse the aging process by hormone balancing and other techniques described herein, do not hesitate at any time, to discuss the reasons for the choices of hormones or any other preparations prescribed for you or any other alternatives possibly available. In addition, be sure to ask your physician at all times that may come up concerning your treatment.

### **Research Study / Photographs**

\_\_\_\_\_ I further consent to the utilization of the results of my progress in any research study performed by Inda Mowett, MD. I understand that my name will not be used and that every effort will be made to protect my privacy. I also understand that photographs taken of me by will not be used without my expressed permission. I understand that I may suspend or terminate my treatment at any time, upon informing physicians in writing via returned mail receipt requested.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



**NOTICE IN ADVANCE OF SERVICE TO PATIENT THAT SERVICE MAY NOT BE COVERED BY MEDICARE OR OTHER INSURANCES**

Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determined that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. I believe that, in your case, Medicare is likely to deny payment for all the blood/diagnostic tests ordered by physicians and the cost for the hormone replacement/balance therapy for the following reasons:

1. The tests and treatments are preventative.
2. The tests and treatments are "not reasonable and necessary" for maintaining health or the prevention of disease according to Medicare law guidelines.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

**Beneficiary Agreement:**

I have been notified by Dr. Mowett and her associates that they believe that, in my case, Medicare is likely to deny payment for the services identified above, for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

\_\_\_\_\_  
Beneficiary Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date