



New Paradigm Wellness

30 E Padonia Rd, #305, Timonium, MD 21093

Phone: (410) 560-7404 fax: (443) 705-0228

WayneBonlieMD@me.com

Today's Date: _____

Patient Information

Name: _____

DOB: _____ / _____ / _____

Address: _____

City/Town: _____

State: _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Email Address: _____

How did you hear about us? _____

What are the top three symptoms or problems related to hormones you would like to change?

1. _____

2. _____

3. _____

Please score the two factors below on a scale from 0 - 10.

0 = None or Terrible 10 = High or Excellent

1. My Energy Level _____ 2. My Sense of Well Being _____

Past Medical History

List Medical Conditions both past and current: _____

Surgeries: _____

Medication Allergies: _____

Current Medications: _____

Supplements and Vitamins: _____

How many hours do you sleep at night: _____

Do you feel rested when you get up in the AM? Yes No

Do you smoke? Yes No How much? _____

Drink Alcohol? Yes No How much? _____

Do you exercise? Yes No How often? _____

Date of most recent:

EKG _____

Stress Test _____

Lipid panel _____

Prostate exam: _____ Name of physician: _____

Please bring copy of most recent blood work with you to your appointment

Stress Level: High Moderate Low

Current Stressors: _____

Family History

Prostate Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Uterine Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Ovarian Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Breast Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Colon Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Thyroid problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

Symptom List - Some of these symptoms will be repeated in different sections because different hormone deficiencies may result in similar symptoms.

COR

Do you ever have the following symptoms?	No Never	Few Sometimes	Moderate Regularly	Much Often	Always Extreme
Poor tolerance to stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety with stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tired during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue or mood improved with sweets or sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salt Cravings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inflammatory disease (arthritis etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies to foods or medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brown spots or increased pigmentation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema, psoriasis or dandruff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar Cravings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weak or tired when standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinate often	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MEL

Do you ever have the following symptoms?	No Never	Few Sometimes	Moderate Regularly	Much Often	Always Extreme
Poor Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty falling asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Awakening at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive pondering of problems at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waking up tired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

THY

Do you ever have the following symptoms?	No Never	Few Sometimes	Moderate Regularly	Much Often	Always Extreme
Sensitive to cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold hands or feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generalized fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue unless exercising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleepy during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distracted easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor motivation for tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water retention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constant swollen eyelids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen eyes in the AM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen calves/feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty losing weight despite dieting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you ever have the following symptoms?	No Never	Few Sometimes	Moderate Regularly	Much Often	Always Extreme
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bedwetting as a child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Slow heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carpal tunnel syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stiff joints in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain worsens in cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hoarse voice in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry skin (general/feet or elbows)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Slow growing or brittle nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diffuse hair loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle achiness or soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low body temperature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diminished sweating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tingling or numbness in extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Course skin (rough skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

T

Do you ever have the following symptoms?	No Never	Few Sometimes	Moderate Regularly	Much Often	Always Extreme
Older looking than age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of feeling of well-being	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of attention to detail	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poorly motivated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive fat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Less muscle mass, strength	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor recovery from activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor endurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor motivation for tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Passive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Too emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rigid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor beard growth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scarce body hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums or poor teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you ever have the following symptoms?	No Never	Few Sometimes	Moderate Regularly	Much Often	Always Extreme
Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pale skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wrinkles on face/palms of hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor endurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor wound healing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor muscle tone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intense sweating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urination problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinary incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of urine after urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen prostate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor libido (sex drive)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty achieving orgasm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased ability to maintain erection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased erection frequency.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased erection firmness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Candida QuestionnairePoint Score

___ Have you been treated for acne with antibiotics for one month or longer?	50
___ Have you taken antibiotics for any type of infection for more than two consecutive months or shorter courses more than three times in a twelve month period?	50
___ Have you ever taken antibiotics - even for a single course?	6
___ Have you ever had vaginitis?	25
___ Have you ever been pregnant?	5
___ Have you ever taken birth control pills?	15
___ Have you ever taken corticosteroids such as Prednisone, Cortisone, Medrol or dexamethasone?	15
___ When exposed to perfumes, insecticide, other odors or chemicals do you wheezing, burning eyes or other distress?	15
___ Are your symptoms worse on damp, humid days or in moldy places?	20
___ Have you ever had fungal infections such as jock itch, athlete's foot, a nail infection or persistent skin infection that was difficult to treat?	20
___ Do you crave sugar or bread?	20
___ Does tobacco smoke cause you wheezing or burning eyes?	10

Please add your points and record your Total Score _____

Policies and Procedures

In the interests of ensuring a smooth process for patient care, please review the following information.

To maximize the time with the provider, ARRIVE 15 minutes prior to your appointment to take vitals and complete paperwork. Out of respect for all of our patients' time, if a patient is late the visit may be shortened to accommodate subsequent scheduled patients. Longer appointment times are available with the provider (please contact our office for details).

General Office Hours

Monday 9:00 am - 4:00 pm
Tuesday 9:00 am - 4:00 pm
Wednesday 9:00 am - 4:00 pm
Thursday 9:00 am - 4:00 pm
Friday 9:00 am - 4:00 pm

CANCELLATION POLICY: If a patient cancels within 24 hours of the appointment or fails to keep the appointment, there will be a \$50 fee.

PATIENT COMPLIANCE: All patients agree to schedule office visits at intervals recommended by the provider who reserves the right to withhold refilling of medications if patients do not follow the recommended office visit/ appointment schedule.

SUBMITTING TO INSURANCE

Although New Paradigm Wellness providers do not participate with any insurance programs patients receive itemized invoices with insurance claim codes for possible reimbursement. Since the providers have opted out of all **Medicare/Tricare** programs, **patients are NOT permitted to submit claims to any Medicare or Tricare** programs for reimbursement.

QUESTIONS FOR THE PROVIDERS: To ensure timely response, questions should be emailed to info@waynebonliemd.com or call the office during regular office hours at 410-560-7404. Please allow 24 hours for a response.

PRESCRIPTION REFILLS: Patients should first contact their pharmacist who will submit a request to our office. Allow 48 hours for all refill requests. **Requests made after 1:00 p.m. on Friday through Sunday may not be reviewed and authorized until Monday.**

SUPPLEMENT ORERS: Our preferred method of receiving supplement orders is via email at info@waynebonliemd.com or at the next visit. Phone orders can be placed during regular office hours Monday through Friday.

I have read, understood and agree to abide by the above policies and procedures. This consent form is valid until all or part is revoked in writing.

Patient Name (Printed)

Patient Signature

Date

CONSENT FOR TREATMENT

I request treatment by Wayne Bonlie, MD or designee. I understand that I have the right, as a patient, to be informed about my condition and the recommended treatment to be used so that I can make an informed decision whether or not to undergo the treatment after I have been told both the potential benefits, risks, and hazards involved.

Some treatments used at New Paradigm Wellness are considered “off label” use by the Food and Drug Administration. In the United States, the regulations of the FDA permit physicians to prescribe or use approved medications for other than their intended indications. The practice is known as “off-label use” or “unlabeled uses”. Such uses are not indicative of inappropriate usage but are legal and common. To access more information on off-label uses, please visit the FDA’s website: www.fda.gov/eder

I agree to comply with any pre-treatment, treatment and post treatment instructions as indicated by the medical provider. I agree to immediately report any adverse reaction or problem to New Paradigm Wellness.

Dr Bonlie will act as primary care only on specific agreement to do so. Many insurance companies do not allow a provider who is not in network to be your primary care provider. Most patients do maintain a separate primary care physician who is in their insurance network. Dr. Bonlie does not have privileges at any hospital and does not do any hospital work.

I understand that New Paradigm Wellness does not accept insurance company payments for possible treatment nor does New Paradigm Wellness coordinate document submission for potential insurance company reimbursement. Any attempt to be reimbursed by an insurance company is solely the patient’s responsibility.

Although New Paradigm Wellness is not subject to the Health Insurance Portability and Accountability Act (HIPAA), we follow HIPAA guidelines regarding patient privacy. We will not release your health information without your consent unless subpoenaed by a court of law.

I have read and understand this consent form and agree to its terms. I understand that payments for procedures at New Paradigm Wellness are non-refundable and that it is possible that these procedure treatments may be of little or no help at all. I have had the opportunity to ask any questions about the treatment including: outcomes, risks, complications and alternative therapies. I further understand that New Paradigm Wellness cannot guarantee the results and will not hold its employees responsible for the individual results of the treatment that I have requested. I also understand that any follow-up treatments required will be at my own expense. This consent form is valid until all or part is revoked in writing.

Patient Name (Printed)

Patient Signature

Date

Provider Signature

Date

Payment, Photo, Email and Text Consent Form

Patient Name: _____ **Date of Birth:** _____

PAYMENT POLICY

I understand that all fees are due at the time of service, unless otherwise specified by the provider.

I understand that there is a 24 hour cancellation policy that I will be charged \$50 for either not showing for an appointment or for canceling an appointment within 24 hours of said appointment.

PHOTOS

By checking one of the boxes below I give the provider permission to use my photographs in the following manner:

- I only want my photos used in the medical chart
- I do not want any photos taken
- Unrestricted use of photographs
This may include lectures, before and after pictures, website, etc.

COMMUNICATION VIA EMAIL AND/OR TEXT

By checking the boxes below I consent to communication/notification of the following:

- Medical information specified to my medical history, diagnosis, treatments and/or recommendations
- Appointment reminders

For Email Notifications enter Email Address: _____

For Text Notifications enter **CELL PHONE #** _____ - _____ - _____

This consent form is valid until all or part is revoked in writing.

Patient's Name

Signature (Parent or Guardian if under 18)

Date

PATIENT INFORMATION & CONSENT

Last Name

First Name

Date of Birth

Address

Apt #

City

State

Zip Code

Home #

Work #

Cell #

Name of emergency contact _____ Relationship _____ Phone _____

INSURANCE (Please circle one of the following)

Do you have:

Medicare

Tricare

Neither

The providers have opted out of all Medicare/Tricare programs, patients are NOT permitted to submit claims to any Medicare/Tricare program for reimbursement.

If you checked Medicare or Tricare do you have a secondary insurance? ___ Yes ___ No

HIPAA Acknowledgement

I hereby acknowledge that I have been made aware that the physicians have a privacy policy in place in accordance with the Health Insurance Portability Act of 1996 (HIPAA). As a patient, I acknowledge that the physician or designee has a privacy policy in effect and has made this policy available to me. I am entitled to an additional copy of the privacy policy if I desire.

I authorize the physician or designee to discuss my medical care and treatment with the following people (spouse, children, parent, etc.)

1. _____ 2. _____

3. _____ 4. _____

I understand this form is valid until all or part is revoked in writing.

X _____
Patient signature or guardian for the minor patient Date

Costs and Fees:

Bioidentical Hormone Patients

1st Visit: \$250

Follow Up Visits \$150

Lab Testing (Blood): Varies/Usually covered by insurance

Medications: Varies. The basic estimate for a standard bio-identical hormone cream is approximately \$70 per month but may be more.