What to expect, what's included in our Hormone Replacement Therapy (HRT) Program

Step 1)
Fill out HRT Program New Patient Forms, submit forms, make an appointment with our receptionist.
Step 2)
Consultation with Dr. Barbara Lubin. She will go over your medical history, habits, symptoms, and individual hormone needs. She will order thorough blood panel and make sure your Mammogram, PAP, and PSA is up to date. If needed we can order your Mammogram (Female), PSA (Male), and schedule your PAP (Female). Follow up appointment will be scheduled at check out.
Step 3)
Follow up appointment. Dr. Lubin will go over your lab / test results. Personalized hormone treatment plan that will be customized for your individual needs. Nutritional & Supplement Recommendations will be provided. Your HRT program is ready to get started! We will monitor your progress and assess the need for any changes in your protocol with our ongoing monitoring and testing (if needed).

Female Patients: Your Mammogram (yearly) and PAP (every 2 years) must be up to date in order to get Pelleted or/and receive Hormone (testosterone/estradiol/progesterone) Prescription.
Male Patients: Your PSA Labs (yearly) must be up to date in order to get Pelleted and/or receive Testosterone Prescription.

Bioidentical hormone replacement is a unique practice and is considered a form of alternative medicine. Even though our physician is Biote certified and is a medical doctor, insurance does not recognize bioidentical hormone replacement as a necessary medicine. Bioidentical hormone replacement is not covered by health insurance in most cases. Insurance companies are not obligated to pay for our services (consultations, HRT Rx, insertions or pellets). We require payment at time of service. WE WILL NOT bill or communicate in any way with your insurance companies.

First Visit/Consultation - $185.00 (Included RMR Test) Follow up visits - $115.00
Female Pelleting - $375.00 (every 4 months) Male Pelleting - $650.00 - $700.00 (every 6 months)
All Rx Refills for HRT (RDT, CREAM, JEL, TROCHE) will be issued for 3 months (90 days) and require in office appointment for every refill.

We accept VISA, MC, DISCOVER, HSA, AND CASH PAY.

My signature on this document is an acknowledgment that I have read and understood the office policies and protocols.

Name: ***Signature:*** ***Date:***

FEMALE PATIENTS - HRT NP FORMS

Name:_____Today'sDate:_____
(Last) (First) (Middle)

Date of Birth: _____ Age: _____ Occupation: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone:_____ Cell Phone:_____ Work: _____

E-Mail Address: _____

In Case of Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone:_____

Primary Care Physician's Name:_)))_____ Phone: _____

How did you hear about us: Website____ Flyer____ My Physician _____ Other_____
Friend ____Friend's Name_____

Marital Status (check one): ( ) Married ( ) Divorced ( ) Widow ( ) Living with Partner ( ) Single

Spouse's Name: _____Relationship: _____

Home Phone: _____ Cell Phone: _____

PLEASE PROVIDE YOUR INSURANCE INFORMATION - FOR LABS/TESTS ONLY

INSURANCE INFORMATION

Primary:

Insurance Company:_____ Policy # _____
Group # _____ **Co-Pay:** _____
Name of Primary Subscriber: _____ Relationship to Patient: _____
Subscriber's D.O.B. _____ Subscriber's SSN _____

Secondary:

Insurance Company:_____ Policy # _____
Group # _____ **Co-Pay:** _____
Name of Primary Subscriber: _____ Relationship to Patient: _____
Subscriber's D.O.B. _____ Subscriber's SSN _____

Signature _____ **Date** _____

Please take time to read this carefully and answer all the questions as completely as possible.

HISTORY

Social:

( ) I am sexually active.
( ) I want to be sexually active.
( ) I have completed my family.
( ) I haven't been able to have an orgasm
( ) My sex has suffered.

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.

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

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):

_____

HYSTERECTOMY: Circle One: YES NO

Level of Activity: **Circle One: Low Medium High**

What type of exercise**:** _____

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: _____

Home Phone: _____ Cell Phone: _____