

BioTE New Patient Package (Female)

*The contents of this package are your first step to restore your vitality.
Please take time to read this carefully and answer all the questions as completely as possible.*

Thank you for your interest in BioTE Medical®. In order to determine if you are a candidate for bio-identical testosterone and/or estradiol pellets, we need laboratory results and your completed medical history forms. We will evaluate your information to determine if BioTE Medical® can help you live a healthier life. If for some reason you are not a candidate for BioTe therapy our providers can discuss alternative therapies with you.

YOU MAY NOT BE A CANDIDATE FOR BIOTE THERAPY IF:

- ❖ You currently have, or were diagnosed with, cancer during the past 24 months
- ❖ You have had a serious cardiovascular event (stroke, heart attack, pulmonary embolus, cardiothoracic surgery) within the past 24 months
- ❖ You have epilepsy or an uncontrolled seizure disorder (seizure within the past 12 months)
- ❖ You are currently pregnant you are NOT a candidate for treatment
- ❖ You are breastfeeding. You may be a candidate for breastfeeding after you discuss the risks versus benefits of BioTE treatment with your provider (determined on a case by case basis)

INSTRUCTIONS FOR PRE-TREATMENT EVALUATION

Visit our website www.NovaWellnessCenter.com and click the “schedule an appointment” button to schedule an appointment for a **BLOOD DRAW**.

You will receive a text message confirming your appointment. There is no charge to reserve the appointment, a payment of \$325 for your lab work and provider appointment will be collected when your blood is drawn at our office. Fasting for 8 hours prior to your blood draw is preferred but NOT required. You may take all medications as you normally do. Please drink plenty of water prior to your blood draw.

BIOTE FINANCIAL POLICY- You will be responsible for payment in full for the services provided. These services are not covered by traditional health insurance in most cases, but you may use a health savings account (HAS) or flexible spending account (FSA) to pay for your treatment. You may request paperwork to submit to your insurance company if you would like to try filing for reimbursement. **We are unable to assist you in obtaining reimbursement other than providing invoices and proof of payment for the services you receive.** We accept the following forms of payment: MasterCard, Visa, Discover, American Express, Care Credit or Cash.





Nova Wellness Center

CLINIC & MEDSPA

Commonly Asked Questions

Q. What is BioTE®?

A. BioTE® is a Bio-Identical form of hormone therapy that seeks to return the hormone balance to youthful levels in men and women.

Q. How do I know if I'm a candidate for pellets?

A. Please complete this packet and return it to our office for review (personally, email, mail or fax). You may then go to our website to schedule an appointment for a **Blood Draw** to have your **Pre-evaluation Lab Work** performed. Schedule a **BioTe Initial Evaluation** appointment with Dr. Sachdev or Lauren Sullivan, PA-C at least 2 weeks after your blood is drawn to discuss your lab results, symptoms and medical history in person. **Please bring the physical copy of your completed new patient packet with you to this appointment.** If it is determined that you are a candidate for BioTe therapy you will then be referred to our office manager to schedule your appointment for the first pellet insertion.

Q. Do I have blood work done before each Treatment?

A. No, only initially and 4-8 weeks later to set your dosing. You may have it done again if there are significant changes.

Q. What are the pellets made from?

A. They are made from wild yams and soy. Wild yams and soy have the highest concentration of hormones of any substance. There are no known allergens associated with wild yams and soy, because once the hormone is made it is no longer yam or soy.

Q. How long will the treatment last?

A. Every 3-6 months depending on the person. Everyone is different so it depends on how you feel and what your provider determines is right for you. If you are really active, you smoke, are under a lot of stress or it is extremely hot your treatment may not last as long. Absorption rate of the hormone from the pellets is based on cardiac output.

Q. Is the therapy FDA approved?

A. What the pellets are made of is FDA approved and regulated, the process of making pellets is regulated by the State Pharmacy Board, and the distribution is regulated by the DEA and Respective State Pharmacy Boards. The PROCEDURE of placing pellets is NOT an FDA approved procedure. The pellets are derived from wild yams and soy, and are all natural and bio-identical which means they are an exact replication of what the body normally makes.

Q. How are they administered?

A. Your practitioner will implant the pellets into the fatty layer underneath the skin of the hip, or lower abdomen. A small incision is made prior to pellet insertion. The incision is small enough that stitches are rarely required.

Q. Does it matter if I'm on birth control?

A. No, your provider can determine what your hormone needs are even if you are on birth control.

Q. Are there any side effects?

A. The majority of side effects are temporary and typically only happen after the first dose. All symptoms are very treatable

Q. What if I'm already on hormone replacement therapy (HRT) of some sort like creams, patches, pills?

A. This is an easy transition, your provider will be able to determine your needs even though you may be currently taking these other forms of HRT.

Q. What if I've had breast cancer?

A. Breast cancer survivors or those with a family history of breast cancer may still be candidates, discuss with your provider.

INITIAL EVALUATION FEE: The first step is to assess and discuss your overall health, symptoms and hormone levels with one of our BioTE providers.

\$325- Hormonal Health Assessment & Consultation- This includes comprehensive lab work, symptom review and a private consult with a BioTE provider to determine whether BioTE therapy is an appropriate treatment option for you. If you are not a candidate, or decide not to try BioTE therapy, other treatment options will be discussed with your provider.

- ❖ **Comprehensive lab work & symptom assessment**
- ❖ **Best-selling book “Age Healthier, Live Happier”** written by Dr. Gary Donovitz
- ❖ **30-minute private consult with a BioTE provider** (via phone or office visit)

TREATMENT COSTS: If you are a candidate and decide to begin BioTE therapy your cost will be as follows

\$695- BioTE 3 Month Start-up Package- This includes a one-hour office visit to discuss your individual treatment plan, first hormone pellet insertion, first 3 months’ worth of EstroDIM supplement, 1st follow up lab work, 1st follow up office visit and administration of booster pellets if necessary.

- ❖ One-hour office visit to discuss your individualized treatment plan and administer your pellets
- ❖ First 3 months’ worth of EstroDIM supplement
- ❖ Access to Dr. Lisa Sachdev’s mobile phone number for 24-hour text support
- ❖ Follow up lab work and symptom assessment 4-6 weeks after your 1st pellet insertion
- ❖ Follow up office consult to review your lab results and response to treatment 5-8 weeks after your pellet insertion
- ❖ Insertion of any additional pellets (“booster dose”) if indicated during your follow up office visit

\$350- BioTE Maintenance Cost- You will know it is time for your next pellet insertion when your symptoms begin to return. Women typically need their pellets replaced **every 2-4 months** depending on their activity level, the majority of our patients need their pellets replaced every 3 months. The cost for pellet insertion is \$350, **this amount will be collected whenever you schedule a pellet insertion appointment online.** The pellet insertion fee does NOT include any additional lab work that your provider may recommend. It also does NOT include any supplements.

Lab Work- A comprehensive health and hormone panel is advised every 12-18 months; the cost is typically \$150-250. Additional lab work may be necessary if there are any changes made to your treatment plan, this is typically done 4-6 weeks after a change is made and costs \$80-\$120.

Supplements- Most are optional, DIM is required to be taken daily and typically costs \$20-30/mo



INSTRUCTIONS AND TIMELINE TO BEGIN BIOTE TREATMENT

- ❖ Obtain a **BIOTE FEMALE NEW PATIENT PACKET** (available in our office or via download from our website).
- ❖ **Review the packet**, especially the medical contraindications listed on page 1, to confirm that you are eligible for treatment.
- ❖ **Complete** the packet and **return it to Nova Wellness Center** (in person, email, mail or fax)
- ❖ Go online to schedule an appointment for a **BLOOD DRAW**. There is no fee to schedule the blood draw. The **\$325 INITIAL EVALUATION FEE** will be collected at our office when your blood is drawn. Fasting for 8 hours is preferred but not required. Take your regular medications and supplements and come WELL HYDRATED to your blood draw appointment. You will be provided with Dr. Donovitz's best selling book *Age Healthier, Live Happier* after your blood is drawn.
- ❖ Our staff will schedule you for a **30-minute CONSULT** with one of our BioTE providers **1-2 weeks after** your blood is drawn. During your consult your provider will review your lab results and medical history and answer any questions you may have regarding treatment options. The consult may be performed in our office or via telemedicine, whichever you prefer. There is no additional charge for the consult, it is included in the initial evaluation fee.
- ❖ If at the end of your consult visit you decide to begin treatment our office manager will contact you to schedule a **one-hour OFFICE VISIT FOR PELLETT INSERTION**. She will also collect the **BIOTE START UP FEE of \$695** which covers your first 3 months of treatment.
- ❖ At the beginning of your **PELLET INSERTION APPOINTMENT** your provider will explain your individualized treatment plan and answer any questions that you may have (30-45 minutes). Your pellets will then be inserted after the procedure is explained, insertion typically takes 10-15 minutes. You will be provided with 2 bottles of EstroDIM supplement to take once daily. Your first pellet insertion and supplements are included in your startup fee, there is no additional cost.
- ❖ After your pellets are inserted you will need to visit our website to schedule a **BLOOD DRAW** for follow up lab work **4- 6 weeks after your pellets are inserted**. There is no additional charge for the lab work, it is included in your start up fee.
- ❖ Our staff will schedule your **FOLLOW UP OFFICE VISIT** with your provider **1-2 weeks after** your blood is drawn.
- ❖ During your **FOLLOW UP OFFICE VISIT** your provider will review your lab results and response to treatment. Additional pellets may be inserted (booster dose) if your initial response to treatment is inadequate. There is no charge for the office visit or booster pellets, this is included in your start up fee.

WHAT MIGHT OCCUR AFTER A PELLET INSERTION (FEMALES)

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; these typically resolve with time.

- **FLUID RETENTION:** 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, taking cider vinegar capsules daily, (found at most health and food stores) or by taking a mild diuretic, which the office can prescribe.
- **UTERINE SPOTTING/BLEEDING:** This may occur in the first few months after an insertion, especially if your progesterone is not taken 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. More than likely, the uterus may be releasing tissue that needs to be eliminated. This tissue may have already been present in your uterus prior to getting pellets and is being released in response to the increase in hormones.
- **MOOD SWINGS/IRRITABILITY:** These may occur if you were quite deficient in hormones. They will disappear when enough hormones are in your system.
- **FACIAL BREAKOUT:** Some pimples may arise if the body is very deficient in testosterone. 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.
- **HAIR LOSS:** Is rare, and usually occurs in patients who convert testosterone to DHT. Dosage adjustment generally reduces or eliminates the problem. Prescription medications may be necessary in rare cases.
- **HAIR GROWTH:** Testosterone may stimulate some growth of hair on your chin, chest, nipples and/or lower abdomen. This tends to be hereditary. You may also have to shave your legs and arms more often. Dosage adjustment generally reduces or eliminates the problem.

Patient Signature

Date



Nova Wellness Center

CLINIC & MEDSPA

Female Patient Questionnaire & History

Name: _____ Today's Date: _____
(Last) (First) (Middle)

Date of Birth: _____ Age: _____ Weight: _____ Occupation: _____

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.
- () My sex has suffered.
- () I haven't been able to have an orgasm.

Habits:

- () I smoke cigarettes or cigars _____ per day.
- () I drink alcoholic beverages _____ per week.
- () I drink more than 10 alcoholic beverages a week.
- () I use caffeine _____ a day.


Nova Wellness Center
CLINIC & MEDSPA
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): _____

Other Pertinent Information: _____

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:

- () Polycystic Ovary Syndrome (PCOS)
- () 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): _____

Year: _____



BHRT Symptom Checklist For Women

Name: _____ Date: _____

Current BHRT therapy: _____

Symptom (please check mark)	Never	Mild	Moderate	Severe
Depressive mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental confusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased sex drive/libido	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood changes/Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine/severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficult to climax sexually	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry and wrinkled skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair falling out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold all the time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swelling all over the body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Family History

	NO	YES
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>

Updated STOP-Bang Questionnaire

Snoring?

Yes No Do you **Snore Loudly** (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?

Tired?

Yes No Do you often feel **Tired, Fatigued, or Sleepy** during the daytime (such as falling asleep during driving or talking to someone)?

Observed?

Yes No Has anyone **Observed** you **Stop Breathing** or **Choking/Gasping** during your sleep?

Pressure?

Yes No Do you have or are being treated for **High Blood Pressure**?

Body Mass Index more than 35 kg/m²?

Yes No

Age older than 50 year old?

Yes No

Neck size large? (Measured around Adams apple)

Yes No For male, is your shirt collar 17 inches/43 cm or larger?
For female, is your shirt collar 16 inches/41 cm or larger?

Gender = Male?

Yes No

SLEEP APNEA RISK SCORING:

Low risk of OSA: Yes to 0-2 questions
Intermediate risk of OSA: Yes to 3-4 questions
High risk of OSA: . Yes to 5-8

or Yes to 2 or more of 4 STOP questions + male gender
or Yes to 2 or more of 4 STOP questions + BMI > 35 kg/m²
or Yes to 2 or more of 4 STOP questions + neck circumference

Scoring Criteria:

SCORE: _____

RISK: ____ low ____ intermediate ____ high

(17"/43cm in male, 16"/41cm in female)



Female Testosterone and/or Estradiol Pellet Insertion Consent Form

Name: _____
(Last) (First) (Middle)

Today's Date: _____

Bio-identical hormone pellets are hormones, biologically identical to the hormones you make in your own body prior to menopause. Estrogen and testosterone were made in your ovaries and adrenal gland prior to menopause. Bio-identical hormones have the same effects on your body as your own estrogen and testosterone did when you were younger, without the monthly fluctuations (ups and downs) of menstrual cycles.

Bio-identical hormone pellets are plant derived and are FDA monitored, but not approved for female hormonal replacement. The pellet method of hormone replacement has been used in Europe and Canada for many years and by select OB/GYNs in the United States. You will have similar risks as you had prior to menopause, from the effects of estrogen and androgens, given as pellets.

Patients who are pre-menopausal are advised to continue reliable birth control while participating in pellet hormone replacement therapy. Testosterone is category X (will cause birth defects) and cannot be given to pregnant women.

My birth control method is: (please circle)

Abstinence Birth control pill Hysterectomy IUD Menopause Tubal ligation Vasectomy Other

CONSENT FOR TREATMENT: I consent to the insertion of testosterone and/or estradiol pellets in my hip. I have been informed that I may experience any of the complications to this procedure as described below. These side effects are similar to those related to traditional testosterone and/or estrogen replacement. **Surgical risks are the same as for any minor medical procedure and are included in the list of overall risks below:**

Bleeding, bruising, swelling, infection and pain; reaction to local anesthetic and/or preservatives; extrusion of pellets; hyper sexuality (overactive Libido); lack of effect (from lack of absorption); breast tenderness and swelling especially in the first three weeks (estrogen pellets only); increase in hair growth on the face, similar to pre-menopausal patterns; water retention (estrogen only); increased growth of estrogen dependent tumors (endometrial cancer, breast cancer); birth defects in babies exposed to testosterone during their gestation; growth of liver tumors, if already present; change in voice (which is reversible); clitoral enlargement (which is reversible). The estradiol dosage that I may receive can aggravate fibroids or polyps, if they exist, and can cause bleeding. Testosterone therapy may increase one's hemoglobin and hematocrit, or thicken one's blood. This problem can be diagnosed with a blood test. Thus, a complete blood count (Hemoglobin & Hematocrit) should be done at least annually. This condition can be reversed simply by donating blood periodically.

BENEFITS OF TESTOSTERONE PELLETS INCLUDE: Increased libido, energy, and sense of well-being; increased muscle mass and strength and stamina; decreased frequency and severity of migraine headaches; decrease in mood swings, anxiety and irritability; decreased weight; decrease in risk or severity of diabetes; decreased risk of heart disease; decreased risk of Alzheimer's and dementia.

I have read and understand the above. I have been encouraged and have had the opportunity to ask any questions regarding pellet therapy. All of my questions have been answered to my satisfaction. I further acknowledge that there may be risks of testosterone and or estrogen therapy that we do not yet know, at this time, and that the risks and benefits of this treatment have been explained to me and I have been informed that I may experience complications, including one or more of those listed above. I accept these risks and benefits, and I consent to the insertion of hormone pellets under my skin. This consent is ongoing for this and all future pellet insertions.

I understand that payment is due in full at the time of service. I also understand that it is my responsibility to submit a claim to my insurance company for possible reimbursement. I have been advised that most insurance companies do not consider pellet therapy to be a covered benefit and my insurance company may not reimburse me, depending on my coverage. I acknowledge that my provider has no contracts with any insurance company and is not contractually obligated to pre-certify treatment with my insurance company or answer letters of appeal.

Print Name

Signature

Today's Date



HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides 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, _____ date _____ 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.