Balanced Bodies
ANTI-AGING CLINIC

CONFIDENTIAL FEMALE EVALUATION

Today's Date: _____

Name: _____ Birthdate: _____ Age: _____

Address: _____
Street City State Zip

Phone: _____ Email: _____

How did you hear about Balanced Bodies?_____

Height: _____ Weight: _____ Desired Weight: _____

Do you use tobacco?	☐ Yes	☐ No	_____
Do you use alcohol?	☐ Yes	☐ No	_____
Do you use caffeine?	☐ Yes	☐ No	_____
Do you exercise?	☐ Yes	☐ No	_____

Allergies: Please list any allergies and describe the reaction that occurred

Drugs: _____

Foods: _____

Other: _____

Medical Conditions/Diseases: Please list any conditions/diseases that you have been diagnosed with or suffer from. (Examples include: Heart disease, high blood pressure, depression, ulcers, arthritis, insomnia, etc).

_____

_____

_____

Current Prescription and Over the Counter Medications (including hormones):

Medication Name and Strength Date Started How Often per day

_____

_____

_____

_____

_____

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List Hormones Previously Taken: Date Started Date Stopped Reason

_____

_____

_____

Have you ever used oral contraceptives (birth control)? ☐ Yes ☐ No

If you experienced any problems, please describe: _____

_____

How many pregnancies have you had? _____ How many children? _____

Any Interrupted pregnancies? ☐ Yes ☐ No

If yes, please explain:_____

Have you had a tubal ligation: ☐ Yes ☐ No If yes, date of surgery: _____ Have you had a hysterectomy? ☐ Yes ☐ No If yes, date of surgery: _____

Reason: _____ Do your ovaries remain? ☐ Yes ☐ No

Do you have a family history of any cancers or osteoporosis? Please list the family member(s):

_____

_____

_____

Have you had any of the following tests performed?

Mammography ☐ Yes ☐ No Date: _____ Outcome: _____

PAP Smear ☐ Yes ☐ No Date: _____ Outcome: _____

Bone Density ☐ Yes ☐ No Date: _____ Outcome: _____

What age did your period start? _____ How many days is/was your cycle (Example: 28): _____

Is/was your menstrual flow heavy or light? _____ Any clots? ☐ Yes ☐ No

Have you ever had what YOU would consider to be abnormal cycles? ☐ Yes ☐ No

Explain: _____

_____

_____

When was your last period? _____ How many days did it last? _____

Do you or have you ever suffered from Premenstrual Syndrome (PMS) symptoms? ☐ Yes ☐ No

Explain: _____

_____

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	Absent	Mild	Moderate	Severe
Hot Flashes	_____	_____	_____	_____
Night Sweats	_____	_____	_____	_____
Vaginal Dryness	_____	_____	_____	_____
Incontinence	_____	_____	_____	_____
Bleeding Changes	_____	_____	_____	_____
Fibrocystic Breast	_____	_____	_____	_____
Weight Gain	_____	_____	_____	_____
Fluid Retention	_____	_____	_____	_____
Dry Skin/Hair	_____	_____	_____	_____
Hair Loss	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____
Depression	_____	_____	_____	_____
Mood Swings	_____	_____	_____	_____
Irritability	_____	_____	_____	_____
Headaches	_____	_____	_____	_____
Breast Tenderness	_____	_____	_____	_____
Cramps	_____	_____	_____	_____
Difficulty Falling Asleep	_____	_____	_____	_____
Difficulty Staying Asleep	_____	_____	_____	_____
Fatigue	_____	_____	_____	_____
Loss of Memory	_____	_____	_____	_____
Foggy Thinking	_____	_____	_____	_____
Acne	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____
Decreased Sex Drive	_____	_____	_____	_____
Harder to Reach Climax	_____	_____	_____	_____
Stress	_____	_____	_____	_____

Other: _____

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What are your goals for taking Hormone Replacement Therapy?

1.

2.

3.

Doctor that we should contact for this therapy:

Name: _____ Phone: _____

Address: _____

Street City State Zip

Weight History (fill out this section if interested in a weight loss program)

When did you first become overweight? (your age then) _____ (year) _____
How did your weight gain start? Describe any circumstances: _____
_____
What do you think is the cause of your weight problem? _____
_____
Your present weight: _____ your weight goal: _____ height: _____
What was your highest weight? (excluding pregnancy) _____your age then ___# of years ago _____
What was your lowest weight? _____your age then _____# of years ago ____
Have you ever stayed the same weight for 10 years or more? Yes:/ No
Have you attempted to lose weight before? _____ most lbs lost: ____ how long it took: ____
Describe previous methods of weight loss (e.g. diets, pills, injections, hypnosis, acupuncture)
and describe your results:_____
_____

Where and when do you do most of your overeating?_____
_____
Please make any comments that you think might be helpful:
_____
_____
_____
Do you currently have any medical concerns? Please List: _____
_____

*** Please include a copy of all relevant lab work, especially hormone levels that you have recently obtained.

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CONSENT FOR BIO-IDENTICAL HORMONE REPLACEMENT THERAPY

Background: You have been diagnosed with or have an increased risk of having a deficiency of one or more hormones and your Provider at Balanced Bodies Anti-Aging Clinic, LLC has recommended treatment with bioidentical hormone replacement therapy (HRT). Some of the bioidentical hormone preparations that may be prescribed for you are regulated by pharmacy compounding laws, which follow the Pharmacy Compounding Accreditation Board (PCAB) guidelines. The use of this therapy as it relates to your diagnosis, while common in functional medicine practices, may be debated in the traditional medical community. You have the right, as a patient, to be informed about your condition and the recommended conventional, integrative, complementary, alternative, non-conventional or non-standard procedures to be used so that you make an informed decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but to simply inform you so you have the information needed to give or withhold your consent to the procedure or treatment.

NOTICE: Refusal to consent to the innovative, integrative, complementary or non-standard procedure shall not affect your right to future care or treatment.

Therapeutic Basis: Many individuals have inadequate hormone levels despite technically normal blood tests. Some individuals suffering symptoms related to menopause or andropause or inability to lose weight may also benefit from these therapies. Bio-identical HRT can be used to augment hormone levels in a number of conditions where diminished hormone levels are evident. Estrogen therapy can maintain vaginal and urethral function and slow the progression of osteoporosis. It may also improve sleep, decrease hot flashes and night sweats, decrease pain and perhaps cognitive function, and improve libido and overall well-being. This therapy may contain one or any combination of the following medications: estriol, estradiol, and/or estrone. Progesterone hormone replacement therapy can offer protection from endometrial cancers, treatment of irregular menstruation, and other low progesterone conditions. It also can improve sleep quality and decrease anxiety. Testosterone hormone replacement therapy is used to treat symptoms or lab tests suggesting suboptimal hormone levels as determined by your provider. Low testosterone symptoms include excessive fatigue, abdominal weight gain, decreased lean muscle, irritability and decreased sexual drive and function.

Objectives: Bio-identical HRT is implemented to optimize hormone levels in the blood, helping to reduce symptoms associated with low levels of these hormones.

Potential Risks: Safety of any of these hormones during pregnancy cannot be guaranteed. Notify your provider if you are pregnant, suspect that you are pregnant, or are planning to become pregnant during this therapy. Estrogen Therapy: Bioidentical estrogens is prescribed as a topical cream. Adverse reactions may include bloating, breakthrough bleeding, breast swelling and tenderness, fluid retention, weight gain, liver cysts, death (e.g.-from blood clots or cancer) and mood swings. Do not take estrogen if you have breast cancer. Progesterone Therapy: Bio-identical progesterone is available in various forms including oral capsules, troches, vaginal or rectal suppositories, and topical creams or gels. Progesterone therapy may be sedating, so it is recommended to coordinate dosing with sleep cycle. Adverse reactions may include bloating, breakthrough bleeding, missed menstrual cycles, breast swelling and tenderness, fluid retention, weight gain, sedation, and depression. Testosterone Therapy: Bio-identical testosterone therapy is available in various forms including topical creams

and injection. Side effects include acne, change in libido, angina or heart attacks, hirsutism (facial hair growth) and scalp hair loss, clitoral engorgement, voice changes, or water retention. If using a formulation of testosterone that is applied to the skin, a local irritation may occur. Although the use of bio-identical hormone replacement therapy has been shown in many studies to be safer than synthetic hormone replacement therapy, the risk of cancer-related side effects is still possible. In fact, there are physicians who do not agree with use bio-identical hormones

Statement of Patient: I understand that along with the benefits of any medical treatment or therapies, there are both risks and potential complications to treatment, as well as not being treated. Those risks and potential complications have been explained to me. I have not been promised or guaranteed any specific benefit from the administration of these therapies and no warranty or guarantee has been made regarding the results of treatment. I agree to proceed with treatment and to comply with recommended dosages. I agree to comply with requests for ongoing testing to assure proper monitoring of my treatments that may include laboratory evaluation of all aforementioned hormone levels or other diagnostic testing by a Balanced Bodies Anti-Aging Clinic, LLC provider, my primary care physician, or other specialist. I agree to see my primary care physician, gynecologist, or other practitioner for regular monitoring and for preventative measures that may include but are not limited to complete physicals, colonoscopy, EKG, mammograms, pelvic/breast exams, pap smears. I agree to immediately report to my physician any adverse reaction or problem that might be related to my therapy. I understand that along with the benefits of any medical treatment or therapies, there are both risks and potential complications to treatment, as well as to not being treated. Those risks and potential complications have been explained to me and I agree that I have received information regarding those risks, potential complications and benefits, and the nature of Bio-identical and other hormone treatments and have had all my questions answered. Furthermore, I have not been promised or guaranteed any specific benefit from the administration of bioidentical hormone therapy. I certify this form has been fully explained to me, that I have read it or have had it read to me and that I understand its contents. I agree not to undergo any treatments unless I fully understand the treatment and have discussed possible risks and benefits. I agree to the therapy described above. I have been educated on the benefits, risks, and possible adverse reactions associated with bio-identical hormone replacement therapy.

Signature of Patient _____ Date_____
Name (PRINT) _____

Statement of Provider: I have explained the risks and benefits of the therapy as detailed above. The patient has verbalized to me his/her understanding of those risks and benefits and gives verbal consent to initiate this therapy. I have explained the therapy, its intended benefits and risks, and possible reactions to the patient. I have confirmed that the patient has no further questions and wishes to initiate bio-identical hormone replacement therapy.

Name of PROVIDER Explaining Procedures: _____

PROVIDER Signature: _____

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Consent for Sermorelin

Please initial after each statement that you have read, agree, and fully understand each statement.

____ 1. I consent to allow Kent Cohen MD and his designated practitioners at Balanced Bodies Anti-Aging Clinic to evaluate, treat and prescribe Sermorelin, which I may use for the off labeled use of anti-aging, preventive medicine and hormone deficiency. Benefits of Sermorelin may include improvement of physical and mental wellbeing, reduction of body fat, increased lean muscle, improved sleep and sexual performance.

____ 2. I am not allergic to Sermorelin or any of its ingredients and will seek immediate medical attention for any signs of anaphylactic reactions including swelling to tongue or throat, difficulty breathing or swallowing, hives or rash.

____ 3. I do not have any known history of cancer, heart problems, pulmonary hypertension, stroke, retinitis pigmentosa, vision loss, bleeding disorders, on blood thinning medications, stomach ulcers, or hematological disorders.

____ 4. I will only use the prescribed recommended dosage of Sermorelin. Using more than prescribed can increase the possibility of adverse side effects.

____ 5. Certain hormones including HGH, Estrogen, Progesterone, Sermorelin, Testosterone can increase the metabolism and growth of cells and could induce underlying cancer growth.

____6. I will notify Balanced Bodies Anti-Aging Clinic and my primary care physician of any changes in my health or medical history.

____ 7. I fully understand the benefits and possible side effects associated with the use of Sermorelin, these may include, but not limited to;

. Nausea/vomiting

. Skin reaction at the injection site including redness, swelling, hives, pain, flushing, infection

. Difficulty swallowing

. Headache

. Chest pain or tightness

. Dizziness

. Sleepiness

. Changes in taste

Notify Balanced Bodies Anti-Aging clinic immediately of these or for any other adverse reactions occur. Most of side effects from the use of Sermorelin resolve without within 24 hours.

____ 8. INDEMNIFICATION CLAUSE: I agree to indemnify defend, protect, and hold harmless Balanced Bodies Anti-Aging Clinic LLC, partners, employees and those affiliated from, against and in respect of all liabilities, losses, claims, damages, punitive damages, causes of action, lawsuits, administrative proceeding, investigations,, demands, judgements, settlement payments, deficiencies, penalties, fines, interest, and cost and expenses suffered, sustained, incurred, or paid by the indemnified parties in connection with, resulting from or arising out pf, directly or indirectly, Balanced Bodies Anti-Aging Clinic LLC rendering medical care, services, advise, and or treatment, my failure to disclose all relevant medical information regarding my medical and physical condition, acts or omissions of Balanced Bodies Anti-Aging Clinic LLC, harm or injury resulting from medical care or pharmaceuticals directly or indirectly by Balanced Bodies Anti-Aging Clinic LLC. I am aware of the risk and potential side effects with the above described treatment, accept all risk involved in taking medications and will not seek indemnification or damages from the indemnified parties.

____9. I acknowledge, understand, and agree to the terms and conditions disclosed herein, including, but not limited to the indemnification clause for any liabilities, arising out of the testosterone replacement therapy rendered by Balanced Bodies Anti-Aging Clinic, LLC.

Print Name_____

Patient Signature_____

Date_____

ACKNOWLEDGEMENT RECEIPT: HIPAA NOTICE OF PRIVACY PRACTICES

In signing this form, you agree that you have received our Notice of Privacy Practices. This Notice, among other points, explains how we plan to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. This applies to the privacy practices of Balanced Bodies Anti-Aging Clinic, LLC. You have the right to review our Notice of Privacy Practices prior to signing this form. It provides details on how we may use and disclose your information. The Notice of Privacy Practices may change periodically. A current copy may be requested from our practice at any time.

By signing this form, you acknowledge you have received our Notice of Privacy Practices and that Balanced Bodies Anti-Aging Clinic, LLC can use and disclose your protected health information in accordance with HIPAA.

Signature of individual or surrogate decision maker:

Date _____

Print Full Name_____

Signature_____

Relationship to patient/legal authority (if applicable)

Date_____

Print Full Name_____

Signature_____

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Healthcare Communication Consent

We now have the ability to email and/or text you to remind you of your appointments. If you would like to receive this feature in the future, please read the consent below and sign.

Patients in our practice may be contacted via email, text messaging, or voice messages to remind you of an appointment and to provide general health reminders/information.

_____ (Patient initials) I consent to receive **text messages** from the practice to my cell phone number listed below.
_____ (Patient initials) I consent to receive **voice messages** from the practice to my number listed below.
_____ (Patient initials) I consent to receive **email** communication, from the practice to the email address listed below.

I **decline** email, text and voice message communications _____ (Please initial)

The email address I authorize to receive email messages for appointment reminders and general health reminders is_____

The phone number that I authorize to receive text messages and voice messages for appointment reminders and general health reminders is (_____)_____-_____

I understand that this request will apply to all future appointment reminders/health information unless I request a change in writing.

24 Hour Appointment Cancellation Policy

Balanced Bodies Anti-Aging Clinic is committed to providing all our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen. Balanced Bodies Anti-Aging Clinic has a 24 hour cancellation policy. If an appointment is missed with less than 24 hour notice there will be a $50 charge.
By signing below, you acknowledge that you have read and understand the Cancellation Policy for Balanced Bodies Anti-Aging Clinic as described above.
Thank you for your understanding and cooperation.

Patient Name: _____
Patients Signature:_____Date:_____