# The Rejuvenation Clinic
## 600 E. 70th St Savannah, GA 31405

## PRIVACY POLICY

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to our practice and its physicians and staff for purposes of treatment, payment and healthcare operations (TPO).

To that end, our practice and its physicians and staff will—
1. Adhere to the standards set forth in the Notice of Privacy Practices.
2. Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and its physicians and staff will not use or disclose PHI for uses outside of practice's TPO, such as marketing, employment life insurance applications, etc. without an authorization from the patient.
3. Use and disclose PHI to remind patients of their appointments unless they instruct us not to.
4. Recognize that PHI collected about patients must be accurate, timely, complete and available when needed. Our practice and its physicians and staff will: Implement reasonable measures to protect the integrity of all PHI maintained about patients.
5. Recognize that patients have a right to privacy. Our practice and its physicians and staff respect the patient's individual dignity at all times. Our practice and its physicians and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.
6. Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its physicians and staff will: a. Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements. b. Not disclose PHI data unless the patient (or his or her authorized representative) has properly authorized the release or the release is otherwise authorized by law.
7. Recognize that although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believes his/her information is inaccurate or incomplete. Our practice and its physicians and staff will— a. Permit patients access to their medical records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patients' appeals. b. Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.
8. All patients and staff of our practice will maintain a list of certain disclosures of PHI for purposes other than TPO for each patient and those made pursuant to an authorization as required by HIPAA rules. We will provide this list to patients upon request, so long as their requests are in writing.
9. All physicians and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.

Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.

## ACKNOWLEDGMENT AND CONSENT

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the physician private practice listed at the beginning of this notice, and how I may obtain access to and control this information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of this practice, its physicians, and staff.

_____
Signature of Patient or Patient's Personal Representative

_____
Print Name of Patient or Patient's Personal Representative

_____
Date

## The Rejuvenation Clinic

Services provided are cosmetic and/or services not covered by insurance. If you feel that your insurance company will cover the services provided, you may submit them to your insurance. All professional services rendered are charged to the patient and due at the time of service.

The patient is responsible for all FEES, regardless of insurance coverage. I agree that should this account be referred for collection, I will be responsible for all collection costs, attorney's fees and court costs. If there is a payment dispute, I waive my privacy protection under HIPAA. I have read and understand all of the above and have agreed to these statements.

Dr. Pettigrew reserves the right to refuse to perform treatments or surgery on anyone who is not deemed an appropriate candidate (whether physically, medically or psychologically).

Signature Date

Revised 5/18

# THE REJUVENATION CLINIC
# PATIENT REGISTRATION

**Patient Information:**

Patient Name: (Last) _____ (First) _____ (MI) _____

Date of Birth: (mm/dd/yy) _____/_____/_____ Age: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____)_____

Email Address: _____

Who referred you or how did you hear about us? _____

Employer: _____ Occupation: _____

**Primary Care Doctor:** _____

**In Case of Emergency:** Name: _____ Relationship: _____

Phone: (_____)_____

**Permission to Treat:** I hereby give my permission to THE REJUVENATION CLINIC to administer treatment. To the best of my knowledge, the information provided to is complete and correct. I understand that it is my responsibility to inform my doctor if I ever have a change in health.

# Male New Patient Package

*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.*

In order to determine if you are a candidate for bio- identical testosterone pellets, we need laboratory and your history forms. We will evaluate your information prior to your consultation to determine if BioTE Medical® can help you live a healthier life. **Please complete the following tasks before your appointment:**

**2 weeks or more before your scheduled consultation:** Get your blood lab drawn at any LabCorp Lab. **IF YOU ARE NOT INSURED OR HAVE A HIGH DEDUCTIBLE, CALL OUR OFFICE FOR SELF-PAY BLOOD DRAWS.** We request the tests listed below. It is your responsibility to find out if your insurance company will cover the cost, and which lab to go to. **Please note that it can take up to two weeks for your lab results to be received by our office. Please fast for 12 hours prior to your blood draw.**

## Your blood work panel MUST include the following tests:

___ Estradiol
___ Testosterone Free & Total
___ PSA Total
___ TSH
___ T4, Total
___ T3, Free
___ T.P.O. Thyroid Peroxidase
___ CBC
___ Complete Metabolic Panel
___ Vitamin D, 25-Hydroxy
___ Lipid Panel (Optional) **(Must be a fasting blood draw to be accurate)**

## Male Post Insertion Labs Needed at 4 Weeks:

___ Estradiol
___ Testosterone Free & Total
___ PSA Total (If PSA was borderline on first insertion)
___ CBC
___ Lipid Panel (Optional) **(Must be a fasting blood draw to be accurate)**
___ TSH, T4 Total, T3 Free, TPO (**Only needed if you've been prescribed thyroid medication**)

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# Male 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: _____

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.
( ) I have used steroids in the past for athletic purposes.

## 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.

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# 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: _____

Other Pertinent Information: _____

_____

## Medical Illnesses:

( ) High blood pressure.
( ) High cholesterol.
( ) Heart Disease.
( ) Stroke and/or heart attack.
( ) Blood clot and/or a pulmonary emboli.
( ) Hemochromatosis.
( ) Depression/anxiety.
( ) Psychiatric Disorder.
( ) Cancer (type): _____
Year: _____

( ) Testicular or prostate cancer.
( ) Elevated PSA.
( ) Prostate enlargement.
( ) Trouble passing urine or take Flomax or Avodart.
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis).
( ) Diabetes.
( ) Thyroid disease.
( ) Arthritis.

I understand that if I begin testosterone replacement with any testosterone treatment, including testosterone pellets, that I will produce less testosterone from my testicles and if I stop replacement, I may experience a temporary decrease in my testosterone production. Testosterone Pellets should be completely out of your system in 12 months.

By beginning treatment, I accept all the risks of therapy stated herein and future risks that might be reported. I understand that higher than normal physiologic levels may be reached to create the necessary hormonal balance.

_____ _____ _____
**Print Name** **Signature** **Today's Date**

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# HEALTH ASSESSMENT FOR MEN

**Name:** _____ **Date:** _____

**E-Mail:** _____

| **Symptom** *(please check mark)* | Never | Mild | Moderate | Severe |
|---|---|---|---|---|
| Decline in general well being | | | | |
| Joint pain/muscle ache | | | | |
| Excessive sweating | | | | |
| Sleep problems | | | | |
| Increased need for sleep | | | | |
| Irritability | | | | |
| Nervousness | | | | |
| Anxiety | | | | |
| Depressed mood | | | | |
| Exhaustion/lacking vitality | | | | |
| Declining Mental Ability/Focus/Concentration | | | | |
| Feeling you have passed your peak | | | | |
| Feeling burned out/hit rock bottom | | | | |
| Decreased muscle strength | | | | |
| Weight Gain/Belly Fat/Inability to Lose Weight | | | | |
| Breast Development | | | | |
| Shrinking Testicles | | | | |
| Rapid Hair Loss | | | | |
| Decrease in beard growth | | | | |
| New Migraine Headaches | | | | |
| Decreased desire/libido | | | | |
| Decreased morning erections | | | | |
| Decreased ability to perform sexually | | | | |
| Infrequent or Absent Ejaculations | | | | |
| No Results from E.D. Medications | | | | |

## Family History

| | NO | YES |
|---|---|---|
| Heart Disease | | |
| Diabetes | | |
| Osteoporosis | | |
| Alzheimer's Disease | | |

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# Testosterone Pellet Insertion Consent Form

Bio-identical testosterone pellets are hormone, biologically identical to the testosterone that is made in your own body. Testosterone was made in your testicles prior to "andropause." Bio-identical hormones have the same effects on your body as your own testosterone did when you were younger. Bio-identical hormone pellets are plant derived and bio-identical hormone replacement using pellets has been used in Europe, the U.S. and Canada since the 1930's. Your risks are similar to those of any testosterone replacement but may be lower risk than alternative forms. During andropause, the risk of not receiving adequate hormone therapy can outweigh the risks of replacing testosterone.

**Risks of not receiving testosterone therapy after andropause include but are not limited to:**
Arteriosclerosis, elevation of cholesterol, obesity, loss of strength and stamina, generalized aging, osteoporosis, mood disorders, depression, arthritis, loss of libido, erectile dysfunction, loss of skin tone, diabetes, increased overall inflammatory processes, dementia and Alzheimer's disease, and many other symptoms of aging.

**CONSENT FOR TREATMENT:** I consent to the insertion of testosterone pellets in my hip. I have been informed that I may experience any of the complications to this procedure as described below. **Surgical risks are the same as for any minor medical procedure.**

**Side effects may include:**
Bleeding, bruising, swelling, infection, pain, reaction to local anesthetic and/or preservatives, lack of effect (typically from lack of absorption), thinning hair, male pattern baldness, increased growth of prostate and prostate tumors, extrusion of pellets, hyper sexuality (overactive libido), ten to fifteen percent shrinkage in testicle size and significant reduction in sperm production.

There is some risk, even with natural testosterone therapy, of enhancing an existing current prostate cancer to grow more rapidly. For this reason, a prostate specific antigen blood test is to be done before starting testosterone pellet therapy and will be conducted each year thereafter. If there is any question about possible prostate cancer, a follow-up with an ultrasound of the prostate gland may be required as well as a referral to a qualified specialist. While urinary symptoms typically improve with testosterone, rarely they may worsen, or worsen before improving. 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 and 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 (secondary to hormonal decline); decreased weight (increase in lean body mass); decrease in risk or severity of diabetes; decreased risk of Alzheimer's and dementia; and decreased risk of heart disease in men less than 75 years old with no pre-existing history of heart disease.

On January 31, 2014, the FDA issued a Drug Safety Communication indicating that the FDA is investigating risk of heart attack and death in some men taking FDA approved testosterone products. The risks were found in men over the age of 65 years old with pre-existing heart disease and men over the age of 75 years old with or without pre-existing heart disease. These studies were performed with testosterone patches, testosterone creams and synthetic testosterone injections and did not include subcutaneous hormone pellet therapy.

I agree to immediately report to my practitioner's office any adverse reactions or problems that may be related to my therapy. 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 treatments and have had all my questions answered. Furthermore, I have not been promised or guaranteed any specific benefits from the administration of bio-identical therapy. I certify this form has been fully explained to me, and I have read it or have had it read to me and I understand its contents. 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 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** |

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# Hormone Replacement Fee Acknowledgment

**Some insurance companies may reimburse patients for the Pellet Hormone Replacement Therapy, there is no guarantee. You will be responsible for payment in full at the time of your procedure.**

**We will give you paperwork to send to your insurance company to file for reimbursement upon request.**

| | |
|---|---|
| **New Patient Consult Fee** | **$150** |
| **Comprehensive Lab Panel** | **$200** |
| **Female Hormone Pellets** | **$375 / $350 cash price** |
| **Male Hormone Pellets (<2000mg)** | **$750 / $710 cash price** |
| **Male Hormone Pellets (>2000mg)** | **$850 / $800 cash** |
| **Interval Labs** | **$40-$60** |

**You may request interval labs whenever you feel your hormones may be unbalanced, but they are usually only drawn after your first set of pellets**

*Price for Lab Work is the self-pay price. You maychoose to use your medical insurance for lab work, but it is recommended to use our account for high deductible plans, as it will cost much less.*

## We accept the following forms of payment:

**Master Card, Visa, American Express, and Cash.**