BIO-IDENTICAL WELLNESS

CHRISTINE FARRELL MSN, FNP-C

Thank you for inquiring about bio-identical hormone therapy and the office of Bio-identical Wellness, Christine Farrell MSN, FNP-C. Whether you are male or female, young or old, bio-identical hormone therapy can offer you greater health and well-being. There is a tremendous amount of research now available telling us that hormones are not only safe, but essential to remaining healthy and preventing diseases such as that Alzheimer's, heart disease, osteoporosis, and even certain cancers.

In our practice, each patient is treated as an individual. There is no "one size fits all" and all treatment regimens are prescribed and followed by us. Being healthy requires treating the whole person-not just the hormones and that is how we run our program. We include recommendations for exercise, diet, supplements, alternative therapies and routine medical care within our normal hormone consultations and follow-ups. Hormones alone will not keep you healthy or feeling good, but they are the key to most of the body's functions and a necessity for good health and wellness.

We offer several types of bio-identical hormone therapy: the traditional creams, sublingual (under the tongue) drops, capsules (certain hormones only) and the Vitapelle hormone implant. Vitapelle delivers a slow continuous amount of hormone into the bloodstream like the ovaries or testicles would. It fluctuates with the needs of the body throughout the day and is completely bio-identical as well. Each person is different in their needs and your treatment will be developed to ensure that it is the right one for your health and lifestyle.

We will start by having you do a 1 hour initial consultation with us. During our consultation we will discuss your symptoms, medical history, family history, diet, exercise, medications/supplements, sleep patterns, stress levels, etc. to form a whole picture. Please bring with you any recent labs, diagnostic tests, lists of medications/supplements- and your questions! We will then order laboratory testing at this time based on your specific needs.

After the consult, we will schedule you a follow-up visit for 2 weeks where we will go over your laboratory results and you will either be prescribed the creams, drops, etc. and start your regimen, or schedule an appointment for the Vitapelle. Follow-up appointments are typically every 3-6 months with new lab testing done based on the patient's needs. We are also available for general medical appointments, PAP smears, and women's health needs. We look forward to meeting with you and partnering with you on your journey to greater health and well being!

-Christine Farrell MSN, FNP-C
Associate Clinical Professor, UCLA

-Jane Hammond PA-C

BIO-IDENTICAL WELLNESS
CHRISTINE FARRELL MSN, FNP-C

PATIENT REGISTRATION INFORMATION

Name_____
FIRST MI LAST

Preferred Name (If different from above)_____**Email**_____

Mailing Address:_____**City:**_____**State:**____**ZIP**_____

Home Phone:___(____)_____**Cell**___(___)_____

- ✓ **Please put a check next the preferred contact number for appointment confirmation**

Date of Birth:_____ **Sex: M F Age:**_____

Marital Status: Minor Single Married Widowed Divorced Separated

Occupation:_____

Employer'sName:_____

Patient's Medical Doctor(Internist/Family/Practitioner/Pediatrician):_____

Pharmacy Name, Location & PhoneNumber:_____

How did you hear about us? Referred by?_____

EMERGENCY CONTACT NAME/ NUMBER:_____

PRIMARY INSURANCE:

Name of Insurance Co:_____

Policy Holder's Name:_____Date of Birth:_____ID#_____

Relation to Patient:_____

Office Policy: Payment is due at the time of your visit. We will provide you with a superbill to send to your insurance carrier for reimbursement to you.

_____ _____
Patient Signature (Parent/guardian if patient is a minor) Date

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Female Medical History

Name_____ Date of Birth_____ Date_____

Current Medications including hormone therapy and supplements (use back if needed)_____
_____
_____

Allergies to Medications_____
_____

Surgery (please use back side if needed) Date
_____ _____
_____ _____
_____ _____
If you had a hysterectomy, please list if one or both ovaries were removed

_____High Blood Pressure
_____Diabetes
_____Migraines
_____Stroke
_____Bleeding Disorders
_____Blood Clots
_____Depression
_____Thyroid problems
_____Asthma/Bronchitis
_____Abdominal Pain
_____Breast Problems
_____Breast Lump
_____Blood In Urine
Other_____
_____Heart Disease/High Cholesterol
_____Ulcers/Gastritis
_____Nervous Disorders
_____Cancer
_____Liver Disorder/Hepatitis
_____Urinary Tract Infection

_____**Family History** of breast cancer. Please list relative and approximate age at diagnosis
Other pertinent family med history_____ _____
_____

WOMEN: _____pre-menopausal _____post-menopausal
Last Mammogram date_____ NORMAL_____ ABNORMAL_____
Last PAP (WOMEN) date_____ NORMAL_____ ABNORMAL_____
Last Bone Density date_____ NORMAL_____ ABNORMAL_____
Last Uterine Ultrasound date_____ NORMAL_____ ABNORMAL_____

Age at 1'st cycle_____ Age at 1'st childbirth_____ Any difficulty with pregnancy?_____
_____Any infertility use? _____
First day of last period_____ How many days does your period last?_____
Are your periods regular?_____
Has the flow changed in any way?_____ If so, how?_____
Do you have any bleeding between periods?_____

A prescription may be given for hormones or a hormone implant may be recommended. Your health care must be continued with your Family Practice / Internal Medicine doctor or Gynecologist. Please share your results with your physician.

A physical/gynecological examination, breast exam, Pap smear, and mammogram are recommended for women prior to starting Hormone Therapy.

Signature _____

Payment is due at the time of service.

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Female Symptom List

Please list your main complaints

1. _____
2. _____
3. _____

Check any symptoms which apply to you:

○ Hot flashes ○ Night sweats ○ Vaginal dryness ○ Incontinence, leakage of urine ○ Increased urinary urge, frequent urination ○ Increased urinary infections ○ Foggy thinking ○ Memory lapse ○ Tearful ○ Depressed ○ Bone loss ○ Weight gain ○ Decreased muscle mss ○ Increased fatty tissue ○ Sleep disturbed, insomnia ○ Headaches, migraine headaches ○ Aches and pains, stiffness ○ Decreased stamina, low energy ○ Decreased libido ○ Nervous, irritable, anxious ○ Easily overwhelmed	○ Hair loss ○ Dry, brittle hair or nails ○ Thinning skin, wrinkles ○ Mood swings ○ Tender, fibrocystic breasts ○ Water retention ○ Allergies ○ Sensitivity to chemicals ○ Stress ○ Salt or sugar craving ○ Low blood sugar ○ Low blood pressure ○ Morning fatigue ○ Evening fatigue ○ Rapid aging ○ Elevated cholesterol ○ Swelling or puffy eyes/face ○ Cold body temperature ○ Decreased sweating ○ Goiter ○ Hoarseness ○ Rapid heartbeat, heart palpitations ○ Constipation ○ Uterine fibroids, bleeding changes (please explain)

Name_____ **Date**_____

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OFFICE POLICIES & FEES

Please note our office policies and protocols. All patients are required to follow these policies for their own health and safety as well as complying with FDA regulated guidelines. Please be aware that these are mandatory policies that apply to all patients. Thank you for your cooperation!

1. All new patients are required to have a consultation prior to starting on hormonal treatment/therapy.
2. All patients are required to return for follow-ups at the prescribed intervals. Typical follow-ups range from 3-6 months, but all patients must be seen at a minimum of every 6 months.
3. Laboratory testing is necessary prior to appointment and will be discussed at patient's appointment.
4. Phone messages/questions will be taken by office staff & discussed with Christine Farrell. Office staff will make callbacks unless otherwise directed. Please schedule an appointment to discuss laboratory tests and/or hormone issues.
5. Patients are required to maintain their general health care as directed: yearly PAP, Mammogram, Prostate exam and PSA testing.
6. Payment is due at time of service. We do not bill insurance, but for the patient's convenience, a super bill will be prepared for the patient to send to the patient's insurance to be reimbursed directly.

Initial: _____

MISSED APPOINTMENTS

We recognize that emergencies and schedule changes occur from time to time, but we ask that you please be considerate and call as soon as possible if you are unable to keep a scheduled appointment. This allows us to fill that time with other patients who are on our waiting list.

A second missed appointment without advance notice will be billed a $50 fee. This charge is directly payable by you and is not billable to insurance. Please note that phone consultations may be scheduled if coming to the office is difficult. Phone consultations will be billed at the time of the appointment.

Follow-up visits for bio-identical hormone patients (other than pellet implants and HCG patients) are mandatory at 3 months, and then every 6 months thereafter. Patients will be asked to come into the office for a visit if they need to discuss their treatment or make changes.

A credit card number is required to hold your initial visit. A missed initial consultation appointment without 24 hour prior notice will be billed at half of the amount of the visit.

Initial: _____

FEE SCHEDULE

Consultation $595.00: One hour initial visit	**Vitapelle Procedure:** Price based on dosage
Office Visit $195.00: Any follow up appointment	**HCG Diet $800.00:** Includes initial visit, 6 follow-up visits and 2 vials of HCG.
Phone Appointment $195.00: These are phone appointments with Christine lasting more than 10 minutes.	**Mini Consultation $295.00:** If patient has not been seen in over a year.
PAP $195.00: Female well woman visit	**Medical Visit $150.00**: Not including hormones

_____ _____ _____

Patient Name Patient Signature Date

BIO-IDENTICAL WELLNESS
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FACILITY & PHYSICIAN ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician and physician's partners , associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement including but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant falls to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services.

_____

Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL SEE ARTICLE 1 OF THIS CONTRACT.

By:_____Date_____ **By:_____Date:_____**

Physician's or Authorized Representative's Signature **Patient or Patient Representative's Signature**

Print or Stamp Name of Physician, Medical Group or Association Name

Christine Farrell MSN, FNP-C
32144 Agoura Road, Ste. 102
Westlake Village, CA 91361

_____

Print Patient Name or Name of Representative and Relationship to Patient

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Hormone Consent

I, _____ hereby authorize Christine Farrell FNP-C to evaluate and treat me with bio-identical hormone therapy. The nature and treatment of this therapy, as well as alternatives, have been explained to me. I am aware that this treatment is not FDA approved, but has undergone medical research. I understand that the Women's Health Initiative study showed synthetic hormone replacement therapy may increase the risks of heart attack, breast cancer and stroke in women. There is now no evidence that bio-identical hormone therapy increases these risks, but long term studies have not been published. While there are many benefits to hormone therapy, there are also risks that include:

- Increased risk of uterine cancer. This risk is minimized by using estrogen with progesterone therapy and may be prevented with annual check-ups and ultrasound of the pelvis.
- Increased risk of abnormal uterine bleeding. Usually related to hormone imbalance , but may be related to uterine fibroids or other abnormalities requiring further treatment.
- Increased menopausal symptoms if not in balance.
- Contraindicated in women with personal history or strong family history of breast cancer.
- Contraindicated in pregnancy and nursing mothers.
- Contraindicated in men with a personal history of prostate or testicular cancer.
- May accelerate the rate of growth of prostate cancer, though studies show it does not increase the risk. A yearly PSA and digital prostate exam are essential while on treatment.

The provider has the right to decline services, if deemed necessary, at any time and for any reason. I understand that it is a requirement of this contract/relationship that I have a yearly OBGYN check up with a minimum of yearly mammograms, pap smears, and pelvic ultrasounds (if indicated). PSA and prostate exam for men.

I understand the above and have had the risks, benefits and alternatives explained to me to my satisfaction. I give my informed consent for bio-identical hormone treatment today as well as for future treatments as needed.

_____ _____

print name **signature/date**

BIO-IDENTICAL WELLNESS
CHRISTINE FARRELL MSN, FNP-C

NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. This notice goes into effect as of Dec. 1, 2010.
We have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

- The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.
- We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.
- We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.
- We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.
- In an emergency, we may disclose your health information t a family member or another person responsible for your care.
- We may release some or all of your health information when required by law.
- If this practice is sold, your information will become the property of the new owner.
- Except as described above, this practice will not use or disclose your health information without your prior written authorization.
- You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.
- You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.
- As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.
- You have the right to transfer copies of your health information to another practice. We'll mail your files for you.
- You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.
- You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing.
- We may or may not make the changes your request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.
- You have the right to receive a copy of the notice
- If we change any of the details of this notice, we will notify you of the changes in writing.
- You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Office, Alora Chua, at (818) 865-8500.

Acknowledgment
I have received a copy of the Notice of Privacy Practices. Date: _____

Signed: _____ Print Name: _____

If signing as a parent or guardian, please write the name of the patient: _____

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Name: _____ Date of Birth: _____/_____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records: examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone

This ***Release of Information*** will remain in effect until terminated by me in writing

Messages

Please call [ ] my home [ ] my work [ ] my cell phone: _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (day) _____ between (time) _____

Signed: _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____

Date of Birth: _____ Date Completed: _____

Please mark below if there is a *personal or family history* of any of the following cancers. If yes, then indicate family relationship and *age at diagnosis* in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

	YOU	Age at Diagnosis	SIBLINGS/ CHILDREN	Age at Diagnosis	MOTHER'S SIDE	Age at Diagnosis	FATHER'S SIDE	Age at Diagnosis
For example: Colorectal cancer	none	–	Brother	36 yrs	Aunt Cousin	44 yrs 58 yrs	Grandfather	65 yrs
BREAST AND OVARIAN CANCER								
Breast cancer (male or female)								
Ovarian cancer								
Breast cancer in both breasts OR multiple primary breast cancers								
Male breast cancer								
Pancreatic or prostate cancer								
Are you of Ashkenazi Jewish descent? ☐ Yes ☐ No								
COLON AND UTERINE CANCER								
Uterine (endometrial) cancer								
Colorectal cancer								
Colon/rectal, uterine/endometrial, ovarian, stomach/gastric, kidney/urinary tract, biliary tract, small bowel, pancreas, brain, and sebaceous adenomas								
10 or more cumulative colon polyps								
MELANOMA								
Melanoma								
Pancreatic cancer								
OTHER CANCER								
_____								

HAVE YOU OR ANY MEMBER OF YOUR FAMILY EVER HAD GENETIC TESTING FOR HEREDITARY RISK OF CANCER?

☐ Yes ☐ No If yes, please explain: _____

If answered "yes", obtain copy of relatives test result.

FOR OFFICE USE ONLY

☐ Patient appropriate for further risk assessment and/or genetic testing
- ☐ BRAC*Analysis*® – A test for Hereditary Breast and Ovarian Cancer syndrome
- ☐ COLARIS® – A test for Lynch syndrome (Hereditary Nonpolyposis Colorectal Cancer)
- ☐ COLARIS *AP*® – A test for Adenomatous Polyposis syndromes
- ☐ MELARIS® – A test for Hereditary Melanoma

☐ Discussed hereditary cancer risk with patient
☐ Patient offered genetic testing
- ☐ ACCEPTED ☐ DECLINED

☐ Follow up appointment scheduled
Date: _____

Myriad Genetic Laboratories, Inc. • 320 Wakara Way, Salt Lake City, Utah 84108 • 800-469-7423 • www.MyriadPro.com

FHQ/06-13

MYRIAD