STEFANIE A. SCHULTIS, M.D.

Stefanie A. Schultis, M.D
110 Lakeview Drive Ste 100 Covington, LA 70433
985-898-1940
www.stefanieaschultismd.com

Revised 1-17-2020

Patient Demographics

PATIENT INFORMATION	**INSURANCE INFORMATION/CASH PATIENT**
Name	
Date of Birth: Age:	HMO PPO OTHER Cash Patient
Social Security #:	MUST COMPLETE INSURANCE INFORMATION
Address:	Name of Insurance:
City, State, Zip:	Name of Insured:
Home#: Cell#:	Relationship:
Work#: Primary#:	Social Security#:
Email:	Date of Birth#:
Religion: Ethnicity:	Employer:
Employer:	Policy#: Group#:
Occupation:	Secondary Insurance:
Marital Status:	
Spouse/Guardian:	Name of Insured:
Date of Birth: Social Security#:	Relationship:
Employer:	Date of Birth: Social Security#:
Occupation: Phone#:	Policy#:
Primary Care Physician:	Group#
Referred by:	
Preferred Pharmacy: Phone#	

Notify in Case of Emergency other than Spouse/Guardian
Name: Relationship: Phone#:

I hereby authorize Dr. Stefanie Schultis and/or her staff to communicate my test results.

Can we call you at: **Home:** YES NO **Cell:** YES NO **Work:** YES NO

Can we leave a message at: **Home:** YES NO **Cell:** YES NO **Work:** YES NO

How did you hear about us?

I hereby authorize Dr. Stefanie Schultis and/or her staff to communicate my test results and/or my medical records to the following:

Name:_____ Relationship:_____

Name: Relationship:

Patient or Responsible Party Signature: Date:

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General Consent to Treat Authorization

Consent for Medical Treatment

I voluntarily consent to medical treatment and diagnostic procedures provided by the above-named physician(s) and their medical personnel. I consent to the testing deemed advisable. I acknowledge that no guarantees have been made as to the result of treatments or examinations.

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time.

I have read and understand the General Consent to Treat Authorization.

_____ Date_____

Signature of Patient or Responsible Party

STEFANIE A. SCHULTIS, M.D.

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Covington, LA 70433
985-898-1940

HIPAA Revised 5-14-20

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted and required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, or your child, to pay your health care bill, to support the operation of the physician's practice, and any other use required by law.

Treatment
We will use and disclose your/your child's protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital surgery may require that you relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations
We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include, as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures
Will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing except to the extent that you physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information
Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information,

You have the right to request restriction of your protected health information.
This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. upon request, even if you have agreed to accept this notice alternatively (i.e., electronically)

You may have the right to have your physician amend your protected health information
If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made. if any. of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice,

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before APRIL 14, 2013

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak to our HIPPA Compliance Officer, Heather Harris in person or by phone at 985-898-1940

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Signature_____

Print Name_____Date_____

Stefanie A. Schultis, M.D.
110 Lakeview Drive Ste 100 Covington, LA 70433
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Revised 5-14-2020

FINANCIAL AND CANCELLATION POLICIES – Hormone Pellets, PRP and Laser Services

Financial

Thank you for choosing us for your medical needs. Some services are not covered by insurance. Payment may be due on the day of service. A $250 deposit may be required at time of scheduling specific procedures.

Packages are expected to be paid as per package contract. Cash, checks and major credit cards (3.5% service charge will be added to credit card payments) are accepted. We can assist you in applying for healthcare financing, if requested.

Cancellations

Cancellations must be 24 hours before your scheduled service or a $50 charge will be applied to your service.

For **NO SHOW's** The $250 deposit will not be refunded.
Please understand if you do not cancel timely, we cannot schedule another patient who may be in need.

I have read and understand the Financial and Cancellation Policies.

_____Date_____

Signature of Patient or Responsible Party

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Hormone Replacement Pellet Therapy Fee Acknowledgement

Insurance does not cover Hormone Replacement Pellet Therapy. It is considered an elective procedure. You will be responsible for payment at the time pellets are inserted.

Female Hormone Pellet Insertion Fee **$350**
*Additional Fee: $10 for women that require a urine pregnancy test prior to insertion

Male Hormone Pellet Insertion Fee **$700**

We accept the following forms of payment:

Mastercard
Visa
Discover
American Express
Debit card
Cash
Check

All credit or debit cards will have an additional processing service fee.

_____ _____

Patient Signature **Date**

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Revised 1-17-2020

Men Medical Health Information Sheet

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. How many per day?_____
( ) I drink alcoholic beverages. How many per week?_____
( ) I drink more than 10 alcoholic beverages a week.
( ) I use caffeine. How much per day? _____

Medical History

Any known drug allergies_____

Have you ever had issues with anesthesia? ( ) Yes ( ) No If yes, please explain_____

_____

Medications Currently Taking:_____

Current Hormone Replacement Therapy:_____

Past Hormone Replacement Therapy:_____

Nutritional or Vitamin Supplements:_____

Surgeries: List all and when:_____

_____

Other pertinent information:_____

Medical Illnesses:

( ) High Blood Pressure
( ) High Cholesterol
( ) Stroke and/or heart attack
( ) Heart Disease
( ) Blood clot and/or pulmonary emboli
( ) Hemochromatosis
( ) Depression/Anxiety
( ) 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 my system in 12 months.

Signature_____Print Name_____Date_____

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Revised 4-21-20

BHRPT Checklist for Men

Name_____ Date_____

Email_____

Symptoms (please check)	None	Mild	Moderate	Severe
Decline in general well-being				
Join pain/muscle ache				
Excessive sweating				
Sleep problems				
Increased need for sleep				
Irritability				
Nervousness				
Anxiety				
Depressed mood				
Exhaustion/lacking vitality				
Declining mental ability/focus				
Feeling burned out/hit rock bottom				
Decreased muscle strength				
Weight gain/belly fat				
Breast development				
Shrinking testicles				
Rapid hair loss				
Decrease in beard growth				
New migraine headaches				
Decreased desire/libido				
Infrequent/absent ejaculations				
No result from ED medications				

Other symptoms that concern you:

_____

_____

_____

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Revised 12-18-19
Men Hormone Packet

Testosterone Pellet Insertion Acknowledgement for Men

General: Bio-identical hormone pellets ae comprised of naturally derived concentrated hormones. These hormones are designed to be biologically identical to the hormones made by our own bodies. Bio-identical hormones have the same effects on the body as one's own hormones.

Benefits and Risks: Advantages of testosterone for men include: a) behavioral changes including decreasing depression, anxiety and irritability, increasing energy and motivation, stabilizing moods, allowing one to cope better, improving self-image and self-worth and enhancing stamina; b) improvement in cognitive function, short term memory and focus: c) decreasing total body fat, increasing muscle mass and increasing bone mass; d) sexual benefits such as increasing libido, early morning erections, firmness, and duration of erections.

The risks are similar to those of any testosterone replacement, but the risks may be lower with pellets than alternative or synthetic forms. The risk of NOT receiving adequate hormone therapy can outweigh the risks of replacing testosterone with pellets in men with low testosterone. These risks include but are not limited to:

Arteriosclerosis, elevation of cholesterol, obesity, loss of stamina and strength, osteoporosis, depression, mood disorders, arthritis, decreased sexual desire and performance, erectile dysfunction, loss of skin tone, diabetes, dementia, Alzheimer's disease and an increased overall inflammatory process.

The above benefits do come with some risks. Very high doses of synthetic testosterone (generally given by injection) or testosterone take orally, have been associated with serious risks, complications and side effects including liver disease, heart disease and elevated cholesterol. However, appropriately dosed, non-oral, natural testosterone used in pellet therapy has not been associated with these problems.

There is some risk, even with natural testosterone therapy, of enhancing the growth of an existing prostate or breast cancer. For this reason, a Prostate Specific Antigen or PSA will be ordered before starting testosterone. If there is any question about possible prostate cancer, a referral to a Urologist will be advised. While urinary symptoms typically improve with testosterone, rarely they may worsen before they improve. Testosterone therapy may increase estradiol levels, and/or hemoglobin hematocrit (thicken the blood). This condition can be reversed by periodically donating blood. A complete blood count (CBC) will be performed before pellet placement. If the blood becomes too thick, thrombosis (formation of a blood clot) may occur and increase the risk of heart attack, stroke or deep vein thrombosis.

Prostate cancer is triggered by the activation of the enzyme aromatase which converts testosterone into estradiol. High levels of estradiol can promote inappropriate cell division (prostate/breast cancer). Anastrazole (aromatase inhibitor) blocks the conversion of testosterone to estradiol. Anastrazole is available in oral and pellet form. (from B1)

Excessive aromatization of testosterone to estradiol may initiate/exacerbate prostate/breast cancer. Aromatase inhibitor pellet placement combined with testosterone pellets reduces aromatization. Some patients may require an oral aromatase inhibitor if excessive aromatization occurs despite administration of anastrazole in pellet form.

The majority of studies show that testosterone is cardioprotective, if given to men with testosterone deficiency in appropriate doses. Men using testosterone therapy also have a decreased incidence of prostate cancer. Lastly, testosterone may help prevent and treat early Alzheimer's disease.

An additional concern, especially in young men, is the suppression of spermatogenesis while on testosterone therapy. However, to date, this appears to be a reversible process in the majority of men. Once testosterone is discontinued, the sperm count is restored, usually in 3-12 months. In rare cases, permanent sterility may result. Younger men, desiring to bear children in the future, are encouraged to have their sperm frozen before initiating testosterone therapy. Men interested in preserving sperm should see a reproductive endocrinologist. Men who are concerned about their future fertility should have a semen analysis prior to initiating testosterone therapy. Testosterone administration is not to be used as a form of male contraception and, should be used cautiously if planning future pregnancies.

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 as described here. **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, pain, and **extrusion of pellets**. Lack of effect (typically from lack of absorption), thinning hair and male pattern baldness. Increased growth of prostate and prostate tumors and overactive libido. **Instructions on the post-pellet recommendation sheet should be followed to avoid such risk.**

Charges: $700 per insertion. I understand payment is due in full at the time of service.

Patient's Consent: I have read and fully understand this consent. I have been encouraged and have had the opportunity to ask questions regarding pellet therapy. All of my questions have been answered to my satisfaction. I further acknowledge 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 theses risk and benefits and I consent to the insertion of hormone pellets under my skin.

I, _____authorize Dr. Stefanie A. Schultis or a designated medical professional to perform the following procedure: **Sterile Placement of Hormone Pellets Under the Skin**.

I have had a digital rectal exam, PSA and CBC within the last year and agree to do this every 6 months to a year as advised.

_____ Date of Birth_____
Patient Name (printed)

_____ Date_____
Patient Signature

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Revised 12-18-19
Men Hormone Packet

What Might Occur After Pellet Insertion In Men

A significant hormonal transition will occur in the first four weeks after the insertion of hormone pellets. Therefore, certain changes might develop that can be bothersome.

- **Pain/Inflammation at Pellet site is expected:** Extrusion of pellets may occur; overt infection is uncommon but can occur.
- **Fluid Retention:** Testosterone stimulates the muscle to grow and retain water which may result in a weight change of two to five pounds. This happens frequently with the first insertion, and especially during hot, humid weather. Swelling of the hands and feet may occur. It may be treated by drinking lots of water, reducing your salt intake, taking cider vinegar capsules daily (found at most health food stores), or by taking a mild diuretic, which the office can prescribe.
- **Breast Tenderness and Nipple Sensitivity:** These may develop with the first pellet insertion of estrogen. The increase in estrogen sends more blood to the breast tissue. Increased blood supply is a good thing, as it nourishes the tissue. To combat the tenderness, an excellent treatment is a capsule of Oil of Evening Primrose 2-3 times a day. You may need to take them for 2-3 weeks.
- **Mood Swings and Irritability:** These occur if you were quite deficient in hormones. They may resolve when enough hormones are in your system.
- **Facial Breakout:** Acne may develop if the body is very deficient in testosterone. This usually lasts only a short period of time and can often be handled with a good face cleansing routine, astringents and toner. If these solutions do not help, please call our office.
- **Hair Loss:** This is rare and usually only occurs in patients who convert testosterone to DHT. Dosage adjustment generally reduces or eliminates the problem. Medibles™ Hair Repair Formula may help with the loss of hair (available online) or a supplement called "Hair, Skin and Nails".
- **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 adjustments generally reduce or eliminate this problem. DHT may also contribute to this, so Mediles™Hair Repair may help.
- **New Medical Conditions:** New medical conditions may be diagnosed while undergoing Pellet Therapy (i.e., cancers, blood clots). If diagnosed with conditions that may be affected (possibly worsened) by hormone therapy while undergoing hormone therapy (breast or uterine cancer, deep venous thrombosis, cardiac or other diseases) **it is not possible to remove the hormone pellets,** but they will wear off in 3-4 months (most of the time) from the last insertion.

I have read and understand the above.

_____ Date_____
Patient Name (print)

_____ Date_____
Patient Signature

_____ Date_____
Physician/Nurse Practitioner Signature

_____ Date_____
Witness

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Hormone Pellet Post Insertion Instructions

1. The insertion site has been covered.
   - The outer layer is the pressure bandage of folded gauze and wide tape. Please remove this anytime after 12 hours. If your procedure was done late in the day, you may sleep with it on and remove it the following morning.
   - The layer next to your skin is a steri strip. These must remain in place for 3 days after the insertion. If steri-strip falls off, apply a band-aid. Apply over the counter antibiotic ointment to site approximately 2x a day until healed.

2. Other important notes:
   - If not allergic take an over the counter Zyrtec or Claritin daily for 3 days starting day of insertion.
   - If you have been given an antibiotic prescription, take as directed.
   - Keep the area clean and dry.
   - Avoid scrubbing the site until the incision is well healed (approximately 7 days).
   - The insertion site may be uncomfortable and you may experience bruising, swelling and/or redness at the site for up to 3 weeks.
   - You may notice pink or bloody discoloration of the outer bandage. This is normal.
   - If you experience bleeding from the incision, apply firm pressure for about 5 minutes. If heavy bleeding persists, call the office.

3. **Restrictions – Men 7 Days, Women 5 Days**
   - No tub baths, soaking water, hot tubs, swimming. Avoid vigorous activity. No Power Walking.
   - Stair stepper, elliptical cross trainer, cycling, jogging, or any activity that uses the gluteal muscles should be avoided. We want to keep the hip as still as possible during this time.

4. Things you **CAN** do:
   - Shower, golf and enjoy life!

5. Infection is very rare. However, if the redness and swelling increase after 48 hours, you may have a minor skin inflammation, infection or bruising.
   - Apply a warm heating pad or warm compress twice daily for 10-15 minutes, or as needed.
   - If symptoms worsen, call the office to be seen or given an antibiotic.

6. Call the office for any questions or concerns: 985-898-1940
   8:30am-4:30pm Mon thru Thursday, 8:30am-11:30am Friday