Brenda Marshall MD

11622 El Camino Real, Suite #100

 San Diego, CA 92130

Phone: 858.663.7699 Fax: 858.764.2405

WELCOME TO OUR OFFICE!

We are pleased you have chosen us to assist you in your healthcare.

INITIAL INFORMATION: Included in this letter you will find important information on how our office functions so we may transform you towards optimal health. Also, enclosed are forms to be filled out and returned to us at the time of your initial consultation.

DR. MARSHALL: Dr. Brenda Marshall holds a Medical Degree (M.D.) from Eastern Virginia Medical School, and is licensed to practice in the State of California. She has been in general medical practice for over 25 years, and she currently specializes in Integrative/Functional and Regenerative Medicine focusing on optimizing health for her patients.

INITIAL CONSULTATION: You will be in our office approximately 1½ hours for your initial and return consultations; please arrive approximately 15 minutes early for appointments to fill out forms. New patients please download and complete initial consult forms **prior** to your arrival. Should you need to cancel or reschedule your appointment with us, we request by telephone at least 72 hours in advance, as it is difficult to fill in the doctor’s schedule on short notice. If we do not receive your cancellation during our office hours at least 72 hours in advance, a $125 cancellation fee will apply. We ask that you make every effort to keep your current appointment as it may take several weeks to reschedule.

INFORMATION TO BRING WITH YOU: In addition to bringing this letter and our completed forms, please bring copies of any current **lab work** and have in mind your goals for the visit. The doctor may give you a lab slip to obtain further lab work, if necessary. Also, bring any **medications/vitamins** you are taking for review.

FOLLOW UP VISITS: The doctor will normally ask for a follow up visit two weeks after your initial consult to review lab results and plan of therapy. Follow up appointments are scheduled as 50 minute appointments. Phone consultations may be appropriate in some cases; the fees are the same as office visits. No insurance is taken for phone consults. You must be seen at least once every six months in order to refill your medications.

CHARGES: All consultation fees are payable at the time of the visit. We accept MasterCard, Visa, AMEX, most HAS cards and cash or checks. We will provide you with a copy of your superbill in order to facilitate your filing of your own insurance. We do not take any insurance at this time. We currently do not take PPO’s, HMO, Medi-cal, Medicare.

LABORATORY: All patients are sent to a Lab Corp/Quest drawing station most convenient for them. Many insurance companies require that you use a specific lab, and it is your responsibility to determine which is contracted with your insurance. Some lab test, including hair metals, mold/mycotoxins, GI-MAP parasites, Saliva cortisol and others are not covered by insurance. Other test like ALCAT food allergy, Neurolab may be covered depending on your carrier.

REFILLS: You must be seen at a minimum once every six months, or depending on your conditions, more frequently, to refill your medications. Although most of these may be natural medicines, they still must be professionally monitored. Please call San Diego Compounding Pharmacy directly for refills @ 858.277.8884 or have your pharmacy fax a refill request to 858.764.2405.

MEDICAL RECORDS: Lab results and plan of treatment are provided at office visits. A full copy of your records is available upon request and requires a signed release authorization. A $25.00 fee may be charged for a full copy.

ARBITRATION FORM: As of May 1st 2008, all patients will be required to read and sign an arbitration agreement. This form is required by our insurance carrier in order to be evaluated and treated by Dr. Brenda Marshall.

OFFICE HOURS: Appointments are available Mondays 12:00pm-5pm, Tuesdays 11:00am – 5pm and Thursdays between 10:00am and 6:00pm. Our shot clinic runs on a walk-in basis during our normal office hours. Phone calls are returned within 24-48 hours depending on urgency, usually in the evenings on Tues/Thurs.

Again, we welcome you to our office and we look forward to assisting you in your efforts to improve your health and healthcare.

Signature:

Date:

Dr. Marshall’s Consultation Service Waiver

11622 El Camino Real, Suite 100

San Diego, CA 92130

Phone: 858.663.7699 Fax: 858.764.2405

**Waiver**

I the undersigned do agree and consent to all medical treatment and services provided by Dr. Marshall and her staff. Medical Services are defined as any and all diagnostics

and treatments and diagnosis provided by Dr. Marshall or her staff. This includes but is

not limited to exercise programs, medicinal and alternative therapies, drug therapy, and any and all efforts to diagnose and treat any condition of myself. I further understand that the Dr. Marshall’s Consultation Service is not a walk in, or emergency services clinic and deals with specialized diagnostics and protocols. In the event that an emergency care need arises, I realize I must go to a medical facility qualified to treat such conditions I understand that any medical services provided to me by Dr. Marshall do not constitute those for life threatening situations.

I agree to hold harmless and indemnify Dr. Marshall and its professionals from any and all claims involving the medical services provided by this service. Further, I understand that Dr. Marshall does not guarantee results and will not assure me progress of any condition or conditions I may have. I understand that successful treatment with Dr. Marshall’s recommendations is primarily based on my own decisions and life choices.

I agree that payment is considered due in full at the time of services or before. Payment may be made with cash, check or credit card or approved PPO insurances. I understand that copays and deductibles not paid at my visit or covered by my insurance will be billed to my credit card held on file.

I acknowledge that this agreement has been fully read and I understand its content.

**Patient’s signature**: **Date:**

*If this pertains to you*: Medicare / Medicaid Agreement

I the undersigned do agree and understand that all treatment and services provided to me by Dr. Marshall and staff are voluntary services provided for my personal benefit. I understand that these services are not covered by Medicare Parts A or B. I agree therefore to pay as fee-for-service and not file under Medicare or Medicaid.

I understand that Dr. Marshall does not submit claims to for reimbursement for Medicare / Medicaid.

Patient’s signature: Date:

**Brenda Marshall, MD**

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 (858) 663-7699

**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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_

**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.

**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:

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**Mammogram Waiver for Testosterone and/or Estradiol Pellet Therapy**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, voluntarily choose to undergo implantation of subcutaneous bio-identical testosterone and/or estradiol pellet therapy, even though I am not current on my yearly mammogram. I understand that such therapy is controversial and that many doctors believe that estradiol replacement in my case is contraindicated. My Treating Provider has informed me it is possible that taking estradiol could possibly cause cancer, or stimulate existing breast cancer (including one that has not yet been detected). Accordingly, I am aware that breast cancer or other cancer could develop while on pellet therapy.

**For today’s appointment I DO NOT have a mammogram for the following reason:**

**( ) My decision not to have one.**

**( ) Unable to provide the report at this time.**

**( ) My doctor’s decision not to have one.** Please provide a note from your treating physician with their rationale as to why they don’t want you to have a mammogram.

I am aware that a current report must be sent by mail or faxed to our office prior to my next HRT appointment. The Treating Provider has discussed the importance and necessity of a mammogram since I receive testosterone and/or estradiol.\_\_\_\_\_\_\_\_\_\_\_\_ (initials of patient)

I have assessed this risk on a personal basis, and my perceived value of the hormone therapy outweighs the risk in my mind. I am, therefore, choosing to undergo the pellet therapy despite the potential risk that I was informed of by my Treating Provider.

I understand that mammograms are the best single method for detection of early breast cancer. I understand that my refusal to submit to a mammogram test may result in cancer remaining undetected within my body. I acknowledge that I bear full responsibility for any personal injury or illness, accident, risk or loss (including death and/or breast, uterine or cancer issues) that may be sustained by me in connection with my decision to not have a mammogram and undergo testosterone and/or estradiol pellet therapy including, without limitation, any cancer that should develop in the future, whether it be deemed a stimulation of a current cancer or a new cancer. I hereby release and agree to hold harmless Dr. Brenda Marshall, Treating Provider & physician, nurses, officers, directors, employees and agents from any and all liability, claims, demands and actions arising or related to any loss, property damage, illness, injury or accident that may be sustained by me as a result of testosterone and/or estradiol pellet therapy. I acknowledge and agree that I have been given adequate opportunity to review this document and to ask questions. This release and hold harmless agreement is and shall be binding on myself and my heirs, assigns and personal representatives.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Patient Print Name Signature Today’s Date**

**Brenda Marshall, MD**

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**PAP and Transvaginal Ultrasound Waiver for Testosterone and/or Estradiol Pellet Therapy**

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , voluntarily choose to undergo implantation of subcutaneous bio- identical testosterone and/or estradiol pellet therapy.

**For today’s appointment I DO NOT have a PAP Smear for the following reason:**

**( ) My decision not to have one.**

**( ) Unable to provide the report at this time.**

**( ) My doctor’s decision not to have one.** Please provide a note from your treating physician with their rationale as to why they don’t want you to have a PAP Smear.

**For today’s appointment I DO NOT have a Transvaginal Ultrasound for the following reason:**

**( ) My decision not to have one.**

**( ) Unable to provide the report at this time.**

**( ) My doctor’s decision not to have one.** Please provide a note from your treating physician with their rationale as to why they don’t want you to have a Transvaginal Ultrasound.

I am aware that a current report must be sent by mail or faxed to our office prior to my next HRT appointment. The Treating Provider has discussed the importance and necessity of a Pap smear and/or Transvaginal Ultrasound since I receive testosterone and/or estradiol.\_\_\_\_\_\_\_\_\_\_\_\_ (initials of patient)

I have assessed this risk on a personal basis, and my perceived value of the hormone therapy outweighs the risk in my mind. I am, therefore, choosing to undergo the pellet therapy despite the potential risk that I was informed of by my Treating Provider.

I understand that PAP smear and/or Transvaginal Ultrasounds are the best single method for detection of early ovarian, endometrial and/or cervical cancer. I understand that my refusal to submit to a Pap smear and/or Transvaginal Ultrasound may result in cancer remaining undetected within my body. I acknowledge that I bear full responsibility for any personal injury or illness, accident, risk or loss (including death and/or cervical, endometrial and/or ovarian cancer issues) that may be sustained by me in connection with my decision to not have a PAP Smear and/or Transvaginal Ultrasound and undergo testosterone and/or estradiol pellet therapy including, without limitation, any cancer that should develop in the future, whether it be deemed a stimulation of a current cancer or a new cancer. I hereby release and agree to hold harmless Dr. Brenda Marshall, Treating Provider and physician, nurses, officers, directors, employees and agents from any and all liability, claims, demands and actions arising or related to any loss, property damage, illness, injury or accident that may be sustained by me as a result of testosterone and/or estradiol pellet therapy. I acknowledge and agree that I have been given adequate opportunity to review this document and to ask questions. This release and hold harmless agreement is and shall be binding on myself and my heirs, assigns and personal representatives.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Patient Print Name Signature Today’s Date**

**Brenda Marshall, MD**

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**Female Testosterone and/or Estradiol Pellet Insertion Consent Form**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Name:** |   |  | **Date:** |   |   |   |   |
| **E-Mail:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| **Symptom (please check mark)** | **Never** |  | **Mild** |  | **Moderate**  |  | **Severe** |
|  |  |  |  |  |  |  |  |
| **Depressive mood** |   |  |   |  |   |  |   |
| **Fatigue** |  |  |  |  |  |  |  |
| **Memory Loss** |   |  |   |  |   |  |   |
| **Mental confusion** |   |  |   |  |   |  |   |
| **Decreased sex drive/libido** |   |  |   |  |   |  |   |
| **Sleep problems** |   |  |   |  |   |  |   |
| **Mood changes/Irritability** |   |  |   |  |   |  |   |
| **Tension** |   |  |   |  |   |  |   |
| **Migraine/severe headaches** |   |  |   |  |   |  |   |
| **Difficult to climax sexually** |   |  |   |  |   |  |   |
| **Bloating** |   |  |   |  |   |  |   |
| **Weight gain** |   |  |   |  |   |  |   |
| **Breast tenderness** |   |  |   |  |   |  |   |
| **Vaginal dryness** |   |  |   |  |   |  |   |
| **Hot flashes** |   |  |   |  |   |  |   |
| **Night sweats** |   |  |   |  |   |  |   |
| **Dry and Wrinkled Skin** |   |  |   |  |   |  |   |
| **Hair is Falling Out** |   |  |   |  |   |  |   |
| **Cold all the time** |   |  |   |  |   |  |   |
| **Swelling all over the body** |   |  |   |  |   |  |   |
| **Joint pain** |   |  |   |  |   |  |   |
| **Family History**  |  |  |  |  |  |  |  |
|  |  |  |  |  | **NO** |  | **YES** |
| **Heart Disease** |   |  |   |  |   |  |   |
| **Diabetes** |   |  |   |  |   |  |   |
| **Osteoporosis** |   |  |   |  |   |  |   |
| **Alzheimer’s Disease** |   |  |   |  |   |  |   |
| **Breast Cancer** |  |  |  |  |  |  |  |

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**BHRT Checklist For Women**

**Brenda Marshall, MD**

1132 El Camino Real, Suite #100, San Diego, CA 92130

 (858) 663-7699

**Hormone Replacement Fee Acknowledgment**

Although more insurance companies are reimbursing 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.

**Female Hormone Pellet Insertion Fee $400**

**We accept the following forms of payment:**

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

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Print Name Signature Today’s Date**

PHYSICIAN-PATIENT 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, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right 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 shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as “Physician”) to a patient, 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.

Filing by Physician 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. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure §§

1280-1295 and the Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator’s fees and expenses.

Article 4: **Retroactive Effect:** The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Severability Provision**: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with California law. I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I may receive a copy if requested.

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: By:

Physician’s or Duly (Date) Patient’s Signature (Date) Authorized Representative Signature

**Brenda Marshall, M.D.**

Print Patient’s Name

Physician

HIPAA

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent.

The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

 Protected health information may be disclosed or used for treatment, payment, or health care operations.

 The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.

 The Practice reserves the right to change the Notice of Privacy Practices.

 The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.

 The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

 The Practice may condition receipt of treatment upon the execution of this Consent.

 The patient acknowledges that he/she has received a copy of our HIPAA practices brochure.

The Consent was signed by:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Printed Name of Patient/Signature Date

Relationship to Patient

(If other than Patient): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practice Representative: Dr. Brenda Marshall

Brenda Marshall MD

CREDIT CARD SIGNATURE ON FILE AUTHORIZATION

Authorization:

I authorize (Brenda Marshall M.D.) to keep my signature and credit card information on file and to directly charge my credit card account for:

[ ] Charges I personally incur

[ ] Charges incurred by the following person(s):

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit card Information:

[ ] Master card [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Visa [ ] American Express

Credit Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_/\_\_\_

3 Digit security code: \_\_\_\_\_

Card Holder’s name (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Holder’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cancellation and Missed**

**Appointment Policy**

We would like to remind you of our office policy regarding missed appointments. Our goal is to provide quality individualized medical care in a timely manner. “No-Shows”, and late cancellations inconvenience those individuals who need access to medical care in a timely manner. This policy enables us to better utilize available appointments for our patients in need of medical care.

If it is necessary to cancel your scheduled appointment, we require that you call at least 72 hours in advance. Appointments are high in demand, and your early cancellation will give another person the possibility to have access to timely medical care.

**As of January 1st, 2017, there will be a charge of $125.00 for no shows and cancellations less than 72 hours in advance. I approve that the credit card on file will be charged.**

Printed Name Signature Date

Brenda Marshall, M.D.

11622 El Camino Real, Suite 100 San Diego, CA 92130

Phone: 858.663.7699 Fax: 858.764.2405