Bio-Identical Hormone Replacement Therapy (BHRT)  
Consultations – Hormone Testing – Compounded Prescriptions – Therapy Plans

If you are not familiar with Bio-Identical Hormone Replacement Therapy (BHRT), please read the enclosed FAQ’s or visit our website at www.MedSaveBemidji.com for more information before continuing the process.

1. Please complete the consultation packet which includes your medical history and symptoms. The packet can be printed off our website or picked-up at our pharmacy. Packets need to be returned before testing or a consultation can be scheduled.

2. Once your packet is returned we will review it and contact you to follow-up with any questions or suggest a hormone test to review your levels. The Saliva test can be purchased at our pharmacy (pricing listed below).
   - $35.00 per hormone level tested with Saliva kit
   - $175.00 for a suggested panel of tests which is most commonly recommended

3. After receiving the results of the saliva hormone test, we will contact you and schedule a hormone consultation (pricing listed below). This initial consultation takes approximately 30-60 minutes to complete. We will cover the results of your hormone levels, an assessment plan if needed, and any recommendations for you to provide to your clinician. Questions or concerns that you may have will also be answered during this time. **Consultations are payable to MedSave Family Pharmacy at time of visit.**
   - $50.00 per consultation
   - $200.00 includes consultation and saliva testing (includes 5 hormones)

4. Following the consultation, our pharmacist will contact your provider with a summary of the consult and a suggested plan for therapy.

5. With prescriber approval we will compound upon receiving the prescription. Compounded prescriptions can be filled for you at MedSave Family Pharmacy or the compounding pharmacy of your choice. At the time of pick-up a pharmacist will review the instructions and answer any usage questions.

6. We will initially follow-up with you within a month after your prescription is filled to answer any usage questions.
Acknowledgment of Receipt of Notice of Privacy Practices

Starting April 14th, 2003, healthcare providers, including pharmacies, must comply with a new set of federal regulations. The regulations are part of the Health Insurance Portability and Accountability Act of 1996 (“HIPPA”), which regards your rights to privacy and handling of Protected Health Information (“PHI”).

One of the rules requires that all of our patients receive our Notice of Privacy Practices at the time of, or prior to, our providing healthcare services, and, that we ask each patient to sign an acknowledgment indicating receipt of that Notice.

Your signature below is proof that you have received the MedSave Family Pharmacy Notice of Privacy Practices. If you have any questions about these practices, or about privacy issues in general, please contact us at MedSave Family Pharmacy.

Signature: __________________________________________

Print Name: __________________________________________

Date: __________________
NOTICE OF PRIVACY PRACTICES
08/01/2013

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.

As part of the federal Health Insurance Portability and Accountability Act of 1996, known as HIPAA, the Facility has created this Notice of Privacy Practices (Notice). This Notice describes the Facility’s privacy practices and the rights you, the individual, have as they relate to the privacy of your Protected Health Information (PHI). Your PHI is information about you, or that could be used to identify you, as it relates to your past and present physical and mental health care services. The HIPAA regulations require that the Facility protect the privacy of your PHI that the Facility has received or created.

This Facility will abide by the terms presented within this Notice. For any uses or disclosures that are not listed below (including Marketing and Selling of PHI), the Facility will obtain a written authorization from you for that use or disclosure, which you will have the right to revoke at any time, as explained in more detail below. The Facility reserves the right to change the Facility’s privacy practices and this Notice.

HOW THE FACILITY MAY USE AND DISCLOSE YOUR PHI
The following is an accounting of the ways that the Facility is permitted, by law, to use and disclose your PHI.

**Uses and disclosures of PHI for Treatment:** We will use the PHI that we receive from you to fill your prescription and coordinate or manage your health care.

**Uses and disclosures of PHI for Payment:** The Facility will disclose your PHI to obtain payment or reimbursement from insurers for your health care services.

**Uses and disclosures of PHI for Health Care Operations:** The Facility may use the minimum necessary amount of your PHI to conduct quality assessments, improvement activities, and evaluate the Facility workforce.

The following is an accounting of additional ways in which the Facility is permitted or required to use or disclose PHI about you without your written authorization.

**Uses and disclosures as required by law:** The Facility is required to use or disclose PHI about you as required and as limited by law.

**Uses and disclosure for Public Health Activities:** The Facility may use or disclose PHI about you to a public health authority that is authorized by law to collect for the purpose of preventing or controlling disease, injury, or disability. This includes the FDA so that it may monitor any adverse effects of drugs, foods, nutritional supplements and other products as required by law.

**Uses and disclosure about victims of abuse, neglect or domestic violence:** The Facility may use or disclose PHI about you to a government authority if it is reasonably believed you are a victim of abuse, neglect or domestic violence.

**Uses and disclosures for health oversight activities:** The Facility may use or disclose PHI about you to a health oversight agency for oversight activities which may include audits, investigations, inspections as necessary for licensure, compliance with civil laws, or other activities the health oversight agency is authorized by law to conduct.

**Disclosures to Individuals Involved in your Care:** The Facility may disclose PHI about you to individuals involved in your care.

**Disclosures for judicial and administrative proceedings:** The Facility may disclose PHI about you in the course of any judicial or administrative proceedings, provided that proper documentation is presented to the Facility.

**Disclosures for law enforcement purposes:** The Facility may disclose PHI about you to law enforcement officials for authorized purposes as required by law or in response to a court order or subpoena.

**Disclosures about the deceased:** The Facility may disclose PHI about a deceased, or prior to, and in reasonable anticipation of an individual's death, to coroners, medical examiners, and funeral directors.

**Uses and disclosures for cadaveric organ, eye or tissue donation purposes:** The Facility may use and disclose PHI for the purpose of procurement, banking, or transplantation of cadaveric organs, eyes, or tissues for donation purposes.

**Uses and disclosures for research purposes:** The Facility may use and disclose PHI about you for research purposes with a valid waiver of authorization approved by an institutional review board or a privacy board. Otherwise, the Facility will request a signed authorization by the individual for all other research purposes.

**Uses and disclosures to avert a serious threat to health or safety:** The Facility may use or disclose PHI about you, if it believed in good faith, and is consistent with any applicable law and standards of ethical conduct, to avert a serious threat to health or safety.

**Uses and disclosures for specialized government functions:** The Facility may use or disclose PHI about you for specialized government functions including: military and veteran's activities, national security and intelligence, protective services, department of state functions, and correctional institutions and law enforcement custodial situations.

**Disclosure for workers' compensation:** The Facility may disclose PHI about you as authorized by and to the extent necessary to comply with workers' compensation laws or programs established by law.

**Disclosures for disaster relief purposes:** The Facility may disclose PHI about you as authorized by law to a public or private entity to assist in disaster relief efforts and for family and personal representative notification.

**Disclosures to business associates:** The Facility may disclose PHI about you to the Facility's business associates for services that they may provide to or for the Facility to assist the Facility to provide quality health care. To ensure the privacy of your PHI, we require all business associates to apply appropriate safeguards to any PHI they receive or create.
OTHER USES AND DISCLOSURES
The Facility may contact you for the following purposes:

Information about treatment alternatives: The Facility may contact you to notify you of alternative treatments and/or products.
Health related benefits or services: The Facility may use your PHI to notify you of benefits and services the Facility provides.
Fundraising: If the Facility participates in a fundraising activity, the Facility may use demographic PHI to send you a fundraising packet, or the Facility may disclose demographic PHI about you to its business associate or an institutionally related foundation to send you a fundraising packet. No further disclosure will be allowed by the business associates or an institutionally related foundation without your written authorization. You will be provided with an opportunity to opt-out of all future fundraising activities.

FOR ALL OTHER USES AND DISCLOSURES
The Facility will obtain a written authorization from you for all other uses and disclosures of PHI, and the Facility will only use or disclose pursuant to such an authorization. In addition, you may revoke such an authorization in writing at any time. To revoke a previously authorized use or disclosure, please contact Julie Laitala to obtain a Request for Restriction of Uses and Disclosures.

YOUR HEALTH INFORMATION RIGHTS
The following are a list of your rights in respect to your PHI. Please contact the Julie Laitala for more information about the below.

Request restrictions on certain uses and disclosures of your PHI: You have the right to request additional restrictions of the Facility's uses and disclosures of your PHI. The Facility is not required to accommodate a request, except that the Facility is required to agree to a request to restrict disclosures to health insurance plans related to products and services you pay out-of-pocket for.

The right to have your PHI communicated to you by alternate means or locations: You have the right to request that the Facility communicate confidentially with you using an address or phone number other than your residence. However, state and federal laws require the Facility to have an accurate address and home phone number in case of emergencies. The Facility will consider all reasonable requests.

The right to inspect and/or obtain a copy your PHI: You have the right to request access and/or obtain a copy of your PHI that is contained in the Facility for the duration the Facility maintains PHI about you. There may be a reasonable cost-based charge for photocopying documents. You will be notified in advance of incurring such charges, if any.

The right to amend your PHI: You have the right to request an amendment of the PHI the Facility maintains about you, if you feel that the PHI the Facility has maintained about you is incorrect or otherwise incomplete. Under certain circumstances we may deny your request for amendment. If we do deny the request, you will have the right to have the denial reviewed by someone we designate who was not involved in the initial review. You may also ask the Secretary, United States Department of Health and Human Services ("HHS"), or their appropriate designee, to review such a denial.

The right to receive an accounting of disclosures of your PHI: You have the right to receive an accounting of certain disclosures of your PHI made by the Facility.

The right to receive additional copies of the Facility's Notice of Privacy Practices: You have the right to receive additional paper copies of this Notice, upon request, even if you initially agreed to receive the Notice electronically.

Notification of Breaches: You will be notified of any breaches that have compromised the privacy of your PHI.

REVISIONS TO THE NOTICE OF PRIVACY PRACTICES
The Facility reserves the right to change and/or revise this Notice and make the new revised version applicable to all PHI received prior to its effective date. The Facility will also post the revised version of the Notice in the Facility.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with the Facility and/or to the Secretary of HHS, or his designee. If you wish to file a complaint with the Facility, please contact Julie Laitala if you wish to file a complaint with the Secretary, please write to:

http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html

The Facility will not take any adverse action against you as a result of your filing of a complaint.

CONTACT INFORMATION
If you have any questions on the Facility's privacy practices or for clarification on anything contained within the Notice, please contact:
Chernugal, Inc. dba MedSave Family Pharmacy
Julie Laitala
217 Paul Bunyan Drive Nw
Bemidji, MN 56601
(218) 759-1222
CONFIDENTIAL
Request for Release of Medical Information

Pharmacy Name: MedSave Family Pharmacy

Pharmacy Address: 217 Paul Bunyan Drive NW Bemidji, MN 56601

I understand that the pharmacist may need to discuss my care with my physician and other health care providers, as well as with my insurance company if required to obtain reimbursement. I do hereby grant permission for MedSave Family Pharmacy to request certain medical/health information from other members of my health care team. This information will be shared with my pharmacist confidentially and specifically for my care.

By signing my name below, I acknowledge receiving a copy of this document and agree to the sharing of my health information between the pharmacist and other members of my health care team. I understand that I may revoke this consent at any time by providing written notice to MedSave Family Pharmacy. I also understand that any release of medical information prior to my revocation shall not constitute a breach of my rights to confidentiality.

Date: _______________

Print Patient Name: ___________________________________________  Patient’s Date of Birth: _____________

Patient/Caregiver Signature: ________________________________________________________________
Confidential Hormone Evaluation

Date: _______________

Patient Name: __________________________________________________________________________  Patient’s Date of Birth: ____________

Address: ____________________________________________________________________________  City, State, Zip: ____________________________

Email Address: ____________________________________________________________________________  Phone: ________________________

Sex: O Male  O Female  Weight: ____________________  Height: ____________________

Do you use tobacco?  O Yes  O No  How often? ____________________________________________

Do you consume alcohol?  O Yes  O No  How much/often? ______________________________________

Do you consume caffeine?  O Yes  O No  How much/often? ______________________________________

Drug Allergies and Reactions (please check the following allergies you may have)

O Aspirin  O Dye Allergies  O Pet Allergies  O Penicillin  O Morphine
O Seasonal  O Codeine  O Sulfa Drug  O Nitrate Allergy  O Other
O No Allergies  Please describe your allergic reaction: ______________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Please complete the following information in preparation for your medication review.

Doctor’s Name: _________________________________________________________________________

Address:  Phone: _________________________________________________________________________
Medical History Continued
Nutritional/Natural Supplements (please identify and list the products you are using)

- Vitamins (multiple or single vitamins such as B complex, E, C, beta carotene)
  List: ________________________________________________________________

- Minerals (calcium, magnesium, chromium, colloidal minerals, various single minerals)
  List: ________________________________________________________________

- Herbs (ginseng, ginko biiboba, Echinacea, other herbal medicinal teas, tinctures, remedies)
  List: ________________________________________________________________

- Enzymes (digestive formulas, papaya, bromelain, Coenzyme Q10)
  List: ________________________________________________________________

- Nutrition/Protein Supplements (shark cartilage, protein powders, amino acids, fish oils)
  List: ________________________________________________________________

- Others (glucosamine)
  List: ________________________________________________________________

Medical Conditions/Diseases (please check all that apply to you)

- Heart Disease
- Blood Clotting Problems
- High Cholesterol or Lipids
- Diabetes
- High Blood Pressure
- Arthritis or Joint Problems
- Cancer
- Depression
- Ulcers
- Epilepsy
- Thyroid Disease
- Headaches/Migraines
- Eye Disease
- Hormonal Related Issues
- Lung Condition (asthma, COPD)

Current Prescription Medications
Medication Name                Strength    Date Started    Frequency per Day
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Medical History Continued

Have you ever used oral contraceptives?  ○ Yes  ○ No  Any Problems?  ○ Yes  ○ No
If YES, please describe any problem(s): __________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

How many pregnancies have you had? ______   How many children? ______
Any interrupted pregnancies?  ○ Yes  ○ No
Have you had a hysterectomy?  ○ Yes – Date of Surgery: ______  ○ No
Were your ovaries removed?  ○ Yes  ○ No
Have you had a tubal ligation?  ○ Yes – Date of Surgery: ______  ○ No
Does your family have a history of any of the following?
  - Uterine Cancer  ○ Yes  ○ No  Family Member(s): ___________________________
  - Ovarian Cancer  ○ Yes  ○ No  Family Member(s): ___________________________
  - Fibercystic Breast  ○ Yes  ○ No  Family Member(s): ___________________________
  - Breast Cancer  ○ Yes  ○ No  Family Member(s): ___________________________
  - Heart Disease  ○ Yes  ○ No  Family Member(s): ___________________________
  - Osteoporosis  ○ Yes  ○ No  Family Member(s): ___________________________

Have you had any of the following tests performed? (check all that apply)
  - Mammography  ○ Yes  ○ No  Date: ___________________________
  - PAP Smear  ○ Yes  ○ No  Date: ___________________________

Since you first began having periods, have you ever had what YOU would consider to be an abnormal
   cycle?  ○ Yes  ○ No  Date: ________________  If YES, please explain (such as age when this
**Rating of Symptoms**

*Please indicate the symptoms you are experiencing.*

<table>
<thead>
<tr>
<th>Symptom</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
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<tbody>
<tr>
<td>Hot Flashes</td>
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<td>Night Sweats</td>
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<td>Incontinence</td>
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<td>Bleeding Changes</td>
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<td>Uterine Fibroids</td>
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<td>Water Retention</td>
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<td>Tender Breasts</td>
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<td>Memory Loss</td>
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<td>Foggy Thinking</td>
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<td>Tearful</td>
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<td>Depressed</td>
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<td>Mood Swings</td>
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<td>Stress</td>
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<tr>
<td>Morning Fatigue</td>
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<td>Evening Fatigue</td>
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<tr>
<td>Difficulty Sleeping</td>
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<td>Decreased Stamina</td>
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<td>Anxious</td>
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<td>Irritable</td>
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<td>Nervous</td>
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<tr>
<td>Fibromyalgia</td>
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<td>Allergies</td>
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<td>Headaches</td>
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How did you arrive at the decision to consider Bio-Identical Hormone Replacement Therapy (BHRT)?

- Doctor
- Self
- Friend/Family Member
- Other: ___________

What are your goals with taking BHRT?

_____________________________________________________________________________________
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Please write down any questions you have about Bio-Identical Hormone Replacement Therapy.

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