REGISTRATION FORM BIHRT PATIENT

(Please Print)

Date: ____________ First Name: _________________________ Last Name: ____________________

Date of Birth: ____________ Age: ___ Sex: □ M □ F SS Number: ____________________

Occupation: ____

Marital Status: (circle one) Single / Married / Divorced / Separated / Widowed / Living with Partner

Home Address: ____

City: ______________________________________ State: ____________ Zip: ____________

Phone: ______________________________________ Other Phone: ____________________

E-mail: ____

In case of Emergency: ____

Relationship to patient: _________________________ Phone: ____________________

Referred to us by: □ Ad in magazine □ Family □ Friend □ Search Engine

□ Website □ Other – please tell us where: ______________________________

FINANCIAL CONSENT FOR HORMONE THERAPY

THIS AGREEMENT is made and executed on ____ (day) of ___________ (month) 2016, between *West Frisco Health and Wellness* and ____ (hereafter called "Patient").

IN CONSIDERATION of *West Frisco Health and Wellness* providing Patient with medical management, administrative, and follow-up services, Patient understands and agrees to the following:

Patient understands that he/she will not request West Frisco Health and Wellness to submit a claim to any third-party payor, even if patient is entitled to benefits, for any portion of the fee or any services rendered to patient on Hormone Therapy. West Frisco Health and Wellness will not accept assignment from any third-party payor as payment for services. Patient understands that Medicare, Medicaid, and Champus require a waiver that states the patient acknowledges the waiving of rights to file a claim to seek reimbursement from these entities or secondary insurance coverage. _____ (initials)

MEDICAL HISTORY QUESTIONNAIRE: Patient will submit a truthful, accurate, and complete Medical History Questionnaire. Patient also acknowledges that failure to provide accurate, truthful, and complete information on this questionnaire or to the Physician(s) of *West Frisco Health and Wellness* could result in inappropriate treatment. _____ (initials)

AUTHORIZATION: Patient authorizes *West Frisco Health and Wellness* to obtain, on Patient's behalf, medical laboratory, diagnostic testing, Physician(s) consulting, and compounding pharmacy supplies. In addition, Patient authorizes *West Frisco Health and Wellness* and the Physician(s) to provide medical care and prescribed pharmaceuticals based on the Medical History Questionnaire, laboratory testing, and other information submitted to *West Frisco Health and Wellness* under this agreement. _____ (initials)

INSTRUCTIONS AND TREATMENT: Patient understands and agrees to comply with the method of instruction, treatment and dosage schedules prescribed by Physician(s); to immediately cease any medical treatment prescribed by Physician(s) in the event of an adverse reaction or side effect arising from prescribed treatment; and to immediately provide to *West Frisco Health and Wellness* Physician(s) with verbal notice via phone call of any such adverse reaction or side effect. Patient understands and agrees that diagnosis and treatment of any medical condition may involve certain risk. _____ (initials)

PRIMARY CARE PHYSICIAN: Patient represents that he/she is under the care of a primary care Physician and that Patient will not rely or substitute the advice of *West Frisco Health and Wellness* Physician(s) should it conflict with the advice of the Patient's primary care Physician. Patient agrees to notify his or her primary care Physician that Patient is receiving hormone therapy. _____ (initials)

LABORATORY FEES: *West Frisco Health and Wellness* will obtain laboratory testing from certified and registered labs in Texas. *West Frisco Health and Wellness* will assist the patient in providing patient's insurance to laboratory for filing. However, patient understands and agrees that patient's insurance coverage may involve co-pays and/or deductibles, which may require patient to be financially responsible for laboratory fees. The laboratory fees are between patient and laboratory. _____ (initials)

HORMONE REPLACEMENT THERAPY: Patient understands and agrees that, although each hormone has been approved by the FDA, the FDA only approves or denies usage of products made by manufacturers which are produced in a specific dosage and form. Therefore, the FDA does not approve or disapprove of hormones which are given in an individual dosage or form for each patient by Physician(s) of *West Frisco Health and Wellness.* I also understand that Physician(s) may choose to discuss with me and provide medications that are off-label in order to offer the widest range of therapies possible. Off-label prescribing is a common and legal practice by most physicians in the US whereby medications are prescribed for purposes other than originally approved. _____ (initials)

WARRANTY: Patient understands and agrees that the methods of medical treatment offered by *West Frisco Health and Wellness* and Physician(s) are not accompanied by any claims, guarantees, or warranties. This agreement remains in effect until revoked by Patient in writing, and photocopies of this assignment shall be construed as valid as the original. _____ (initials)

RESCHEDULING: If patient needs to reschedule or cancel appointment, he/she agrees to notify *West Frisco Health and Wellness* within 24 hours of scheduled appointment. Patient understands that failure to do so, regrettably, will result in a $100 “no-show” fee. _____ (initials)

Patient’s Printed Name Date of Birth

Patient/Legal Representative’s Signature Today’s Date

Witness Today’s Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand West Frisco Health and Wellness reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy on the clinic website and in the physician's office. I may request a copy of the updated Notice of Privacy Practices by calling my physician's office or requesting a copy in person at any of my appointments.

Patient's Printed Name	Date of Birth
Patient/Legal Representative's Signature	Date
Witness	Date

I wish to be contacted in the following manner: **(Please list phone number that is best number for nurses to call)**

Telephone Number: ____

☐ Ok to leave message with detailed information.
☐ Leave message with call-back number only.

Email address: ____

☐ I authorize West Frisco Health and Wellness to contact me using the email address provided above.
☐ I understand my name, information regarding my account balance could be viewed by anyone who has access to my email and that if my email is unsecured, the information could potentially be intercepted.

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for West Frisco Health and Wellness to share my protected health information with:

Name/Relationship	Contact Phone Number
Name/Relationship	Contact Phone Number
Name/Relationship	Contact Phone Number
Name/Relationship	Contact Phone Number

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

West Frisco Health and Wellness
4280 Main Street Suite 200
Frisco, TX 75033
Phone: (972) 464-2510 Fax: (214) 705-1379

NAME:

(LAST) (FIRST) (MIDDLE)

DOB: _________________**PREVIOUS NAME:** __________________________**SOCIAL SECURITY#** __________________________

☐ I request and authorize to release healthcare information of the patient named above to**:**
West Frisco Health and Wellness, 4280 Main Street Suite 200; Frisco TX 75033

Physician/Practice: Name, address, phone and fax number (whom you want to release your records):

The request and authorization applies to:

☐ Healthcare information relating to the treatment, condition, or dates listed below

☐ **All healthcare information including information relating to HIV/AIDS testing sexually transmitted diseases, psychiatric disorders / mental health or drug and/or alcohol use.**

☐ All healthcare information excluding information relating to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders / mental health or drug and/or alcohol use.

☐ Other (describe in box below)

Patient Signature	Date Signed

By signing name above you are hereby authorizing your records to be transferred.

THIS AUTHORIZATION STAYS IN EFFECT UNLESS OTHERWISE SPECIFIED OR REVOKED IN WRITING

Welcome to our practice. Please fill out the information below to the best of your ability.
Hormone Therapy Questionnaire History

Patient Name: ______________________________________ Date filed out form:_______________________________________

Primary Care Physician: ______________________________ **Phone Number**: _______________________________________

Date of Last Visit with Primary Care Physician: ______________________________

Personal Medical History			**Previous Surgeries/Serious Injuries (When?)**
Diabetes (Type _____)	N	Y	____
High Blood Pressure	N	Y	____
Cancer (Type_______)	N	Y	____
Stroke	N	Y	____
COPD	N	Y	____
High Cholesterol	N	Y	____
GERD	N	Y	____
Arthritis	N	Y	____
Gout	N	Y	____
Sleep Apnea	N	Y	____
Asthma	N	Y	***Local Pharmacy**____
Thyroid Disorder	N	Y	____
Allergic Rhinitis	N	Y	**Mail Pharmacy**____
Other	N	Y	____

Patient Social History

Use of Alcohol:	Daily	Weekly	Monthly	Occasionally	Rarely	Never
Use of Tobacco:	Daily	Previously, but Quit	(Age Stopped_______)			Never
Use of Caffeine:	Yes / No	Type/Frequency ______________________________				
Use of Drugs:	Never	Type/Frequency ______________________________				
Do you exercise?	Yes / No	If yes, please describe: ____				

Family Medical History

	Age	Diseases	If Deceased, Cause of death
Father	_____	______________________________________	______________________________
Mother	_____	______________________________________	______________________________
Brother(s)	_____	______________________________________	______________________________
Sister(s)	_____	______________________________________	______________________________
Son	_____	______________________________________	______________________________
Daughter	_____	______________________________________	______________________________

Patient Name: ___________________________________ Date of Birth: _______________

ALLERGIES (Medications and Dyes)	
Item(s) that you are *allergic* to:	**Reaction(s) you have had from the *medication*, you are allergic to:**

MEDICATIONS AND SUPPLEMENTS THAT YOU TAKE ON REGULAR BASIS			
Drug Name (Brand name, or generic name)	**Dosage**	**Times taken within 24 Hours**	**Reason for taking Medication**

BIO-IDENTICAL HORMONE THERAPY SYMPTOMS

Patient Name: ________________________________ Date of Birth: ___________ Date: __________________

Please answer the yes or no questions; then go on to the Male or Female questions based on your gender.

Yes	No		Severity if yes (Mild, Moderate, Severe		
□	□	Decreased sense of well-being	□ Mild	□ Moderate	□ Severe
□	□	Thinning or loss of hair	□ Mild	□ Moderate	□ Severe
□	□	Difficulty sleeping	□ Mild	□ Moderate	□ Severe
□	□	Heat or cold intolerance	□ Mild	□ Moderate	□ Severe
□	□	Decreased energy	□ Mild	□ Moderate	□ Severe
□	□	Decreased skin tone	□ Mild	□ Moderate	□ Severe
□	□	Decreased concentration, memory	□ Mild	□ Moderate	□ Severe
□	□	Mood swings	□ Mild	□ Moderate	□ Severe
□	□	Decreased sex-drive	□ Mild	□ Moderate	□ Severe
□	□	Sadness, depression	□ Mild	□ Moderate	□ Severe
□	□	Decreased muscle strength	□ Mild	□ Moderate	□ Severe
□	□	Hot flashes	□ Mild	□ Moderate	□ Severe
□	□	Increased fat deposits	□ Mild	□ Moderate	□ Severe
□	□	Prolonged exercise healing	□ Mild	□ Moderate	□ Severe

□ □ Have you ever been on hormone therapy before? If yes, please explain ________________________________

□ □ Are you on current hormone replacement therapy? If yes, please explain ________________________________

□ □ Have you ever been on a testosterone program? If yes, please explain ____

□ □ Do you have a stent in your heart vessels? If so when were they placed? ________________________________

□ □ Have you ever had a stroke? If yes, please explain ____

□ □ Have you ever had any issues with anesthesia? If yes, please explain ____

MEN ONLY

Yes	No		Severity if yes (Mild, Moderate, Severe)		
□	□	Do you have shrinking Testicles?	□ Mild	□ Moderate	□ Severe
□	□	Do you have decrease in beard growth?	□ Mild	□ Moderate	□ Severe
□	□	Do you decreased morning erections?	□ Mild	□ Moderate	□ Severe
□	□	Do you have infrequent or absent ejaculations?	□ Mild	□ Moderate	□ Severe
□	□	Do you have prostate cancer?			

MEN ONLY – CONT.

How many times do you empty your bladder at night? ______ Has this changed in the last 12 (twelve) months? ________________

Have you had a kidney, bladder, or prostate infection in the last 12 (twelve) months? ____

Do you have blood in your urine? ____

Date and result of last PSA test: ____

Do you have problems with erectile dysfunction or ejaculation? ____

Have you had no results from E.D. medications? ____

Social (check off)

- ☐ 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.

WOMEN ONLY

Date of last menses: _______________ Number of pregnancies: _____________ Number of live births: _____________

Are you pregnant or breast-feeding? _______________________

Birth Control Method:
Abstinence / Birth Control Pills / IUD / Hysterectomy / Menopause / Tubal Ligation / Vasectomy / Other: _____________

What are your main PMS symptoms? ____

Most recent mammogram and results: ____

Most recent pap smear and results: ____

Most recent bone density and results: ____

Yes	No		Severity if yes (Mild, Moderate, Severe)		
☐	☐	Do you have vaginal dryness?	☐ Mild	☐ Moderate	☐ Severe
☐	☐	Do you have difficult to climax sexually?	☐ Mild	☐ Moderate	☐ Severe
☐	☐	Do you have breast cancer?			
☐	☐	Have you had a Hysterectomy? If yes, circle if	Total hysterectomy / Partial hysterectomy / Radical hysterectomy		

Social (check off)

- ☐ 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.