Name: _____ Date of birth: _____

HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services, www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other health-care providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM.

Print name: _____

Signature: _____ Date: _____

Name: _____ Date of birth: _____

FEMALE PATIENT QUESTIONNAIRE & HISTORY

Name: _____ Date: _____

Date of birth: _____ Age: _____ Weight: _____ Occupation: _____

Home address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Work: _____

Preferred contact number: _____

May we send messages via text regarding appts to your cell? ☐ Yes ☐ No

Email address: _____ May we contact you via email? ☐ 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 means you have 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.

Name: _____ Relationship: _____

Home phone: _____ Cell phone: _____ Work: _____

Social:

☐ I am sexually active.	OR	☐ I want to be sexually active.	☐ I do not want to be sexually active.
☐ I have completed my family.	OR	☐ I have NOT completed my family.	
☐ My sex life has suffered.	OR	☐ I have not been able to have an orgasm or it is very difficult.	

Habits:

☐ I smoke cigarettes or cigars_____per day. ☐ I use e-cigarettes_____a day. ☐ I use caffeine_____a day.

☐ I drink alcoholic beverages_____per week. ☐ I drink more than 10 alcoholic beverages a week.

Name: _____ Date of birth: _____

FEMALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

Drug allergies

Drug allergies: _____ If yes, please explain: _____

Have you ever had any issues with local anesthesia? ☐ Yes ☐ No Do you have a latex allergy? ☐ Yes ☐ No

Medications currently taking: _____

Current hormone replacement? ☐ Yes ☐ No If yes, what? _____

Past hormone replacement therapy: _____

Family history:

☐ Heart disease ☐ Diabetes ☐ Osteoporosis ☐ Alzheimer's/dementia ☐ Breast cancer ☐ Other_____

Pertinent medical/surgical history:

- ☐ Breast cancer
- ☐ Uterine cancer
- ☐ Ovarian cancer
- ☐ Polycystic ovaries/PCOS
- ☐ Acne
- ☐ Excess facial/body hair
- ☐ Infertility
- ☐ Endometriosis
- ☐ Epilepsy or seizures
- ☐ Fibrocystic breast or breast pain
- ☐ Uterine fibroids
- ☐ Irregular or heavy periods
- ☐ Menstrual migraines
- ☐ Hysterectomy with removal of ovaries
- ☐ Partial hysterectomy (uterus only)
- ☐ Ophorectomy removal of ovaries only

Birth control method:

- ☐ Menopause
- ☐ Hysterectomy
- ☐ Tubal ligation
- ☐ Birth control pills
- ☐ Vasectomy
- ☐ IUD
- ☐ Infertility
- ☐ Other _____

Name: _____ Date of birth: _____

FEMALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

Medical history:

- ☐ High blood pressure or hypertension
- ☐ Heart disease
- ☐ Atrial fibrillation or other arrhythmia
- ☐ Blood clot and/or a pulmonary embolism
- ☐ Depression/anxiety
- ☐ Chronic liver disease (hepatitis, fatty liver, cirrhosis)
- ☐ Arthritis
- ☐ Hair thinning
- ☐ Sleep apnea
- ☐ High cholesterol
- ☐ Stroke and/or heart attack
- ☐ HIV or any type of hepatitis
- ☐ Hemochromatosis
- ☐ Psychiatric disorder
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Lupus or other autoimmune disease
- ☐ Other _____

FEMALE HEALTH ASSESSMENT QUESTIONNAIRE

NAME: _____ EMAIL: _____

TODAY'S DATE: _____ PHONE: _____

Please mark the appropriate box for each symptom you may be experiencing.

SYMPTOMS	NONE	MILD	MODERATE	SEVERE	VERY SEVERE
Physical Exhaustion (fatigue, lack of energy, stamina or motivation)	☐	☐	☐	☐	☐
Sleep Problems (difficulty falling asleep or sleeping through the night)	☐	☐	☐	☐	☐
Irritability (mood swings, feeling aggressive, angers easily)	☐	☐	☐	☐	☐
Anxiety (feeling overwhelmed, feeling panicky, or feeling nervous)	☐	☐	☐	☐	☐
Decline in drive or interest (loss of "zest for life," feeling down or sad)	☐	☐	☐	☐	☐
Joint and muscular symptoms (joint pain, muscle weakness, poor recovery after exercise)	☐	☐	☐	☐	☐
Difficulties with memory (concentration, finding the right word, or retaining information)	☐	☐	☐	☐	☐
Vaginal dryness or difficulty with sexual intercourse	☐	☐	☐	☐	☐
Sexual Problems (change in desire, activity, orgasm and/or satisfaction)	☐	☐	☐	☐	☐
Sweating (night sweats or increased episodes of sweating)	☐	☐	☐	☐	☐
Hot Flashes (burst that starts in chest and lasts for short duration)	☐	☐	☐	☐	☐
Hair loss, thinning or change in texture of hair	☐	☐	☐	☐	☐
Feeling cold all the time, having cold hands or feet	☐	☐	☐	☐	☐
Headaches or migraines (increase in frequency or intensity)	☐	☐	☐	☐	☐
Weight (difficulty losing weight despite diet/exercise)	☐	☐	☐	☐	☐
Bladder problems (difficulty in urinating, increased need to urinate, incontinence)	☐	☐	☐	☐	☐

Other symptoms or unique health circumstances to take into consideration:

Name: _____ Date of birth: _____

HORMONE REPLACEMENT FEE ACKNOWLEDGMENT & INSURANCE DISCLAIMER

Preventative medicine and bioidentical hormone replacement is a unique practice and is considered a form of alternative medicine. Even though the physicians and nurses are board certified as medical doctors, nurses, nurse practitioners and/or physician assistants, insurance does not recognize bioidentical hormone replacement as necessary medicine BUT rather more like plastic surgery (aesthetic medicine). Therefore, bioidentical hormone replacement is not covered by health insurance in most cases.

Insurance companies are not obligated to pay for our services (consultations, insertions or pellets, or blood work done through our facility). We require payment at time of service and, if you choose, we will provide a form to send to your insurance company with a receipt showing that you paid out of pocket. WE WILL NOT, however, communicate in any way with insurance companies.

This form and your receipt are your responsibility and serve as evidence of your treatment. We will not call, write, pre-certify, appeal nor make any contact with your insurance company. If we receive a check from your insurance company, we will not cash it but will return it to the sender. Likewise, we will not mail it to you. We will not respond to any letters or calls from your insurance company.

For patients who have access to Health Savings Account, you may pay for your treatment with that credit or debit card. Some of these accounts require that you pay in full ahead of time, however, and request reimbursement later with a receipt and letter. This is the best idea for those patients who have an HSA as an option in their medical coverage. It is your responsibility to request the receipt and paperwork to submit for reimbursement.

New patient office visit fee ..... Includes inital lab panel ..... $ 275

Female hormone pellet insertion fee ..... If you choose to do pellet replacment therapy ..... $ 350

We accept the following forms of payment:

Check, Cash, Visa, MC, HSA

Print name: _____

Signature: _____ Date: _____