Regain Natural Hormone and Wellness Center

Name: _____Today's Date: _____

Date of Birth: _____ Age: _____

Height: _____ Weight: _____

Street Address: _____

City: _____State: _____Zip: _____

Phone Numbers: Home: _____Cell: _____

Email Address 1 _____

Email Address 2_____

Employed by: _____

Occupation: _____

Business Address: _____

Business Phone: _____

Marital Status: (please circle) Single Married Divorced Widow

Spouse – Significant Other's Name: _____ DOB: _____

Spouse – Significant Other's Phone Number: _____

In Case of Emergency, whom shall we notify: _____

Phone Number: _____

How did you hear about us? _____

Signature: _____ Date: _____

The Success of Your Andropause Therapy Depends on What You Tell Your Provider

Many Symptoms of Andropause Syndrome can be effectively treated. Please check off which symptoms you have experienced

Improved Date		Improved Date	
☐	Irritability	☐	Joint/ Backache
☐	Lethargy/Fatigue	☐	Palpatitions
☐	Depression	☐	Crying Spells
☐	Headaches	☐	Burning Upon Urination
☐	Hot Flashes	☐	Pain Upon Urination
☐	Forgetfulness	☐	Erectile Dysfunction
☐	Weight Gain	☐	Decreasead Sexual Desire
☐	Insomnia	☐	Decreased Sexual Activity
☐	Other, Please Explan		

PATIENT NAME			DOB		ALLERGIES		
DATE START	DATE STOP	MEDICATION	QTY	LAST FILLED	REFILLS	PHARMACY	

		Notes
Mamogram		
Colonoscopy		
Annual		
Labs		
Hemoglobin		
PSA		

Male Consent to Treat

I _____, am at least 18 years old and have requested the Regain Natural Hormone and Wellness Center prescribe testosterone for me.

The medical provider has explained to me the risks of administering testosterone could include stimulation of previously undetected prostate cancer, elevation of blood pressure changes in liver function and thickening of blood. In the administration of testosterone therapy, I understand that I must donate blood in order to alleviate blood thickening. I am committed to donating blood minimally at 3 month intervals or more frequently according to the direction of the medical staff. My provider has also explained to me the possible side effects of administering testosterone such as increased muscle mass, acne, depression, sleep, sleep disorders and other emotional side effects.

I am aware that administration of bio-identical testosterone may or may not have the same effects as other forms of testosterone, and may have other, as yet unknown side effects. I understand that although administration of bio identical testosterone appears to have fewer side effects, there may be unreported side effects from its use. I am willing to accept the risk.

I agree to monitor my body through regular prostate exams, blood pressure checks, and other tests and procedures recommended by my practitioners while I am taking hormones. I understand that I may stop taking these hormones at any time. I will inform my provider if I change the dose or frequency or if I discontinue them. I have had opportunity to ask and receive satisfactory answers to all my questions.

Patient Signature Date

Notice of Privacy Practices-HIPAA

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 healthcare 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, text message or 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 or services that you might find valuable or informative.

3. We will use your health information for billing that may be sent to your or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, tests and supplies used in the course of your care in our office.

4.. 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.

5. 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.

6. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

7. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

8. We agree to provide patients with access to their records in accordance with state and federal laws.

9. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

10. 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.

Signature: _____ Date: _____

Insurance Policy

Preventive medicine and bio-natural hormone replacement is a unique practice and is considered a form of alternative medicine. Even though the Physicians and Medical Staff are Board Certified as Medical Doctors, Physician Assistants, Nurse Practitioners, and Registered Nurses, insurance does not recognize it as necessary medicine and it is therefore considered an elective treatment. Our treatments are not typically fully covered by most health insurance carriers.

Regain Natural Hormone and Wellness Center is not associated with any insurance companies, which means insurance companies are not obligated to pay for our services (labs, new patient exams, hormone injections, orals, pellets, or insertions). We require payment at the time of service. We can provide our patients on request with insurance forms that can be submitted to insurance providers for possible partial reimbursement on treatments. We are not responsible to communicate with insurance providers as we are considered out of network.

Regain staff will not call, write, pre-certify, or make any contact with your insurance company. We also do not respond to any follow up letters from a patient's insurance provider.

Insurance companies will be directed to reimburse the patient directly.

We do not accept Medicare or Medicaid and do not provide insurance forms to be filed for out of network services. Our services are not reimbursable under Medicare law.

I have read the above information and agree to comply with all Regain policies in regard to insurance reimbursement for hormone therapy or any other treatment we use in our office.

Good Health!

The Regain Staff

Signature_____ Date_____