The Hormone & Wellness Center

MEDICAL RECORDS RELEASE

Date: _____

To: _____

_____

_____

_____

RE: _____
(Patient's Name)

_____ _____
Date of Birth Social Security Number

This will authorize you to release a copy of:

____ Recent physical exam/pap (women)

____ Recent physical exam/prostate (men)

_____ Recent lab results (blood work, pap smear results, PSA results)

_____ Recent mammogram results

_____ Recent DEXA Scan results

_____ Other: _____

To:

The Hormone & Wellness Center
2507 Harrison Avenue, Suite #201
Panama City, FL, 32405
Phone: (850)-215-4455 Fax: (850)-215-4492

Patient's Signature: _____

-Acknowledgements and Consent to Treatment for Men-

The Nature of the Treatment
In andropause, men gradually lose their ability to produce testosterone and some men develop elevated levels of estrogen. As men undergo an ever increasing loss of testosterone, they are faced with anxiety, irritability, erectile dysfunction, bone loss, muscle loss, loss of strength, and loss of energy and memory impairment.

I hereby give my consent to Michelle Hines-Bautista, ARNP and staff for evaluation, diagnosis and treatment of andropause, thyroid disorders, adrenal fatigue/stress, and other hormone imbalances by the administration of hormone replacement therapy and/or nutritional supplements, including vitamins, minerals and anti-oxidants and/or drugs designed to alter hormones.

The possible side effects for men on testosterone are acne, oily skin and hair, undesired hair growth, enlargement of the prostate, loss of sperm production (sterility), enlargement of breast tissue, testicular atrophy (shrinking), and in some studies, an increased risk of prostate cancer growth.

Safety of Hormone Replacement
The majority of data points toward the safety of treating low testosterone. Nevertheless, I understand that the careful surveillance and close monitoring are requirements of all patients because prostate cancer arises in 1 out of 6 men. Testosterone may be a growth stimulant for existing prostate cancer and is withheld during cancer treatment.

I understand that no guarantee has been made to me regarding the outcomes of this treatment or on resolution of my symptoms. I understand that not all patients receive the same degree of response. I also understand that the benefits derived from therapy will cease if the therapy is discontinued.

I understand that each hormone may or may not have been approved by the FDA for the use employed by my physician. I acknowledge that off label use of FDA approved drugs is legal and widely practiced.

I understand that some hormonal and non-hormonal supplements that may be recommended are available over the counter and have not been submitted for evaluation by the FDA. These products conform to the cosmetic and food supplement labeling laws, which prevent claims of usefulness on the label. Lack of claims on a label does not imply uselessness but rather that the contents are not categorized as “drugs”.

I agree not to proceed to treatment unless all of my questions have been answered to my satisfaction. I will be responsible for administering the treatments prescribed to me. I will use the recommended doses and agree to get follow-up lab as recommended. I understand that failure on my part to follow my physician’s recommendations in dosage and follow-up lab may result in potentially harmful problems.

I certify that I am under the regular care of another physician for all other medical conditions. I understand that this is a specialized practice and does not hospitalize patients. I also understand that I will continue under the care of my other physician(s) for any ongoing medical condition as well as for any medical consultation that I may need.

I hereby acknowledge that the nature and purpose of portions of the aforementioned treatment are considered by some to be medically unnecessary and/or experimental because they are not aimed at “treating a disease.” And there are no long-term studies documenting the results. The risks involved and the possibilities of complications have been explained to my satisfaction. I understand that the treatment to be provided may be considered experimental and unproven by scientific testing and peer-reviewed publication.

I further consent to the utilization of the results of my progress in any research study performed by my physician. I understand that my name will not be used. I understand that I may suspend or terminate treatment at any time and hereby agree to immediately notify the physician of any such suspension or termination.

I consent to evaluation and treatment as described above.

Signature: _____ Date: _____

Print Name: _____

-PATIENT REGISTRATION FORM-

The Hormone & Wellness Center

PATIENT INFORMATION: (Please use full legal name, no nicknames) Today's Date_____

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) ____-_____ Cell Phone: (____) ____-_____Work Phone: (____) ____-_____

Preferred contact phone number: Home___ Work ___ Cell ___ E-mail: _____

Social Security #: _____ Date of Birth: ____/____/_____ Age: _____ Sex: _____

Employer Name and Address: _____

Emergency Contact Name: _____ Relationship to Patient: _____

Emergency Phone: (____) ____-_____ Date of Birth: ____/____/_____ Social Security #: _____

If patient is a minor, please list person responsible for account: _____

Please tell us how you heard about us: _____ *Referred by:* _____

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID card and picture ID)
IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, INCLUDE DATE OF BIRTH FOR INSURANCE CLAIMS

PRIMARY INSURANCE: Plan Name: _____ Insured's Name: _____

Insured's Social Security #: _____ Insured's Date of Birth: _____/_____/_____

Relation to Patient: _____ Policy ID/Contract #: _____ Group #: _____

SECONDARY INSURANCE: Plan Name: _____ Insured's Name: _____

Insured's Social Security #: _____ Insured's Date of Birth: _____/_____/_____

Relation to Patient: _____ Policy ID/Contract #: _____ Group #: _____

Disclosure & Consents

PLEASE READ THE FOLLOWING, INTIAL EACH ONE, AND SIGN AT THE BOTTOM

ASSIGNMENT OF BENEFITS: I hereby authorize direct payment of my insurance benefits to The Hormone & Wellness Center for services rendered to me by Michelle Bautista, ARNP. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that The Hormone & Wellness Center is unable to collect from my insurance carrier for whatever reason. **Initial: _____**

MEDICARE/ CHAMPUS/ INSURANCE BENEFITS: I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my medical records that these programs may request. **Initial: _____**

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION: I certify that I have received and read a copy of the Hormone & Wellness Center's Patient Information Privacy Policy. I hereby authorize The Hormone & Wellness Center to release any medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits. **Initial: _____**

LAB/ X-RAY/ DIAGNOSTIC SERVICES: I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason. **Initial: _____**

AUTHORIZATION TO MAIL, CALL, OR E-MAIL: I certify that I understand the privacy risks of mail, phone calls, or e-mail. I hereby authorize a Hormone & Wellness Center representative, or my healthcare provider to mail, call, or e-mail me with the communications regarding my healthcare, including, but not limited to: appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying The Hormone & Wellness Center to that effect in writing. **Initial: _____**

CONSENT TO TREATMENT: I hereby consent to evaluation, testing, and treatment as directed by my Hormone & Wellness Center healthcare provider or her/his designee. **Initial: _____**

PATIENT SIGNATURE: _____ DATE: _____

Patient Name: _____ Date of Birth: _____/_____/_____

The Hormone & Wellness Center Office Policies and Procedures

PLEASE READ AND SIGN PRIOR TO BEING SEEN:

At The Hormone & Wellness Center, we strongly believe in patient education and teaching. Therefore, extra time is scheduled and spent with each and every patient on the initial consultation appointment and the second office visit, which is to review the results of lab work and initiate hormone replacement therapy if necessary. This time is above and beyond that which is customary for most office visits. Hormone replacement therapy is very specialized and therapy is specific to each individual's needs. For this reason, we feel that this extra time for teaching and education is necessary for the patient to fully understand how hormones effect the patient's overall health and wellbeing. This extra time is billed to your insurance company and you will see this additional charge when you receive the explanation of benefits from your insurance company. If you are not comfortable with this charge, please let the office staff know prior to your appointment so that other arrangements can be made in addressing your hormone replacement care. By signing this consent form, you acknowledge that you are aware of this billing practice.

SIGN: _____ **DATE**: _____

Please read and initial the following, then sign at the bottom:

***Collection Policy:** Payment is due when services are rendered. Insurance companies require payment of co-pays/ co-insurance at the time of service. Patient balances not received within 30 days of their visit will be billed and are subject to a fee of 10% of the unpaid balance per month. Special arrangements must be made prior to your appointment if you are unable to pay at the time of service. A credit card installment agreement is available if you are unable to pay at the time of service. Self-pay patients requiring lab work can pay for their lab work through the office, but a credit card agreement must be signed in order to do so. Any balances that are over 90 days old, with no attempt on the patient's part to pay or make payment agreements will be turned over the Credit Bureau and a 50% collection fee will be accessed to the balance to cover collection costs.

INITIAL: _____

****NO SHOW/ LATE CANCELLATION POLICY**:** The Hormone & Wellness Center requires a 24 business hours (Monday-Friday) notice for appointment cancellations. Patients will be charged $75.00 for missing their 1st or 2nd appointment, and $50 for the consecutive appointments. **INITIAL: _____**

* It is the patient's responsibility to know the date and time of her/his appointment. Appointment reminder calls are made as a courtesy, but because there could be circumstances which would prevent the reminder call from being completed, (phone disconnected, phone temporarily out of order, full mailbox, busy signal, or no answer) reminder calls should not be solely relied upon as the only means of keeping track of your appointment. **INITIAL: _____**

***** The office will verify the patient's health benefits: however, this is not a guarantee of payment. It is the patient's responsibility to know her/his benefits including deductibles, co-pays, and visit limitations and whether the office is in network with their insurance company. In addition, it is the patient's responsibility to keep track of visits during her/his benefit year. **INITIAL: _____**

*** Prescription Refills.** Prescription refills will not be administered to any patient who has not been in for an office visit in the past 6 months. Prescriptions will also not be filled for any patient who has a past due balance for 90 days or more. Prescription refill requests require a minimum of 48 hours to process. This could take longer if changes in medication are required. Remember, compounded medications are made to order and may require extra time. *Please do not allow your compounded medication to run out before calling in for a refill.* Your prescription request may not be approved if you have not kept your scheduled appointment. **INITIAL: _____**

* Please notify The Hormone & Wellness Center in a timely manner of any changes, including: Insurance coverage, address and telephone number. Delay in providing us with the accurate insurance information may prevent insurance reimbursement, and the patient will be responsible for fees. **INITIAL: _____**

* There will be a $30 charge for any returned checks. The patient will be notified by phone if a returned check is received. If no attempt is made to make payment on the returned check, a warning letter will be sent to the patient giving the patient 15 days to repay the check. If no payment is made, the check will be taken to the state attorneys office for prosecution. Any legal fees accessed will be the patient's responsibility. If there is a history of 2 returned checks, our office will only accept cash or credit card payments. **INITIAL: _____**

* Testosterone is classified as a controlled substance. Patient's receiving testosterone therapy must be seen at their regularly scheduled appointments (6 months or less depending on the patient) in order to continue getting prescriptions. **INITIAL: _____**

* Messages for the nurse will be answered in the order that they are received. Please allow at least 24 hours for your message to be returned. If your question is complex and the nurse is unable to answer your question, an appointment with the nurse practitioner will be required. **INITIAL: _____**

* The Hormone & Wellness Center requires that any patient receiving hormone replacement therapy keep their annual recommended well exams (Pap-smears & mammograms (for women), Prostate exams (for women), DEXA Scans, and colonoscopies) up to date. **INITIAL: _____**

* *The Hormone & Wellness Center is a specialty care clinic and does not provide primary care.* If a medical issue is discovered that is unrelated to hormones (example: high blood pressure, high cholesterol, pain management), the patient will be referred back to their primary care physician. If the patient does not have a primary care physician, our staff will be happy to assist in referring you to a qualified provider. **INITIAL: _____**

* Patients are seen by appointment only. If a patient walks in and requests to see the nurse practitioner, the patient will be asked to schedule an appointment to be seen. **INITIAL: _____**

* Patients who are on hormone replacement therapy are required to be seen at least every six months in order for their prescriptions to be refilled. Some patients require more frequent follow-up appointments, however, the provider will determine this. Patients on testosterone, antidepressants, thyroid medication, or blood pressure medication are required to be seen a minimum of every six months, NO EXCEPTIONS, in order to receive prescription refills. **INITIAL: _____**

* Patients who chronically no show or have numerous late cancellations will not be allowed to schedule future appointments, and will be seen on a call in basis only. (Patient calls in on the day she/he can come and IF there is an opening, the patient will be schedule for an appointment). **INITIAL: _____**

*Laboratory Services: Due to the number of patients who require blood work, patients are encouraged to go to an outside lab for their blood draws. If circumstances make it impossible for the patient to use an outside lab, the blood can be drawn in the office and sent to the lab, but the patient will be required to pay a $25 blood draw fee for this service. **INITIAL: _____**

* Reminder calls are made as a courtesy to remind the patient that their follow up appointment is due. Unfortunately, circumstances arise that prevent the reminder calls from being completed. It is ultimately up to the patient to keep track of when appointments are due. If you see that your medication is about to run out and there are no more refills, it is an indication that you are due to come in for a follow up appointment. **INITIAL: _____**

* At times, our staff may need to contact you in order to give you information regarding your treatment. If we are unable to reach you then we may leave a detailed message (particularly on your cell or home phone). If you would not like us to leave any detailed messages please let us know. **INITIAL: _____**

*Follow up appointments should be scheduled at least two weeks in advance. **INITIAL: _____**

*If the patient is more than 10 minutes late for their scheduled appointment, the patient will be asked to reschedule when they arrive. **INITIAL: _____**

I have read and understand the above policies.

PATIENT SIGNATURE: _____ DATE: _____

****

PRIVACY STATEMENT

The privacy and security of your personal health information is of paramount importance to us. Please read the privacy statement below and sign.

"I hereby authorize The Hormone & Wellness Center to release any of my medical records, including radiology test results, laboratory test reports, medication instructions, or appointment time information to the people/entities listed below."

Please include the names of any individual that may accompany you in the exam room for your appointment.

I understand that I have the right to rescind this authorization at any time by notifying The Hormone & Wellness Center to that effect in writing.

_____ _____
(Please Print) (Please Print)

_____ _____
(Please Print) (Please Print)

_____ _____
(Please Print) (Please Print)

Authorized Signature: _____

Date: _____

The Hormone & Wellness Center

Name: _____

Date: _____

Adult Health History Form

Your answers on this form will help your health care provider better understand your medical concerns and symptoms. If you are unable to remember specific details, please provide your best guess.

Age: _____ **Main reason for today's visit:** _____

Other concerns: _____

PLEASE LIST ANY ALLERGIES OR REACTIONS TO MEDICATIONS:

_____

MEDICATIONS: Please list any prescription and non-prescription medicines, vitamins, home remedies, birth control pills, etc. that you use.

Medication	Dose	Times per day

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems

____ Heart Disease _____ High Blood Pressure _____ High Cholesterol

____ Asthma/Lung Disease _____ Diabetes _____ Thyroid Problems

____ Kidney Disease _____ Mental Illness (specify): _____

_____Cancer (specify type): _____ ____ Other (specify): _____

How would you rate your general health? Excellent___ Good___ Fair___ Poor___

MAJOR HEALTH EVENTS (heart attack, seizure, stroke, etc.), including the date:

_____

_____

REVIEW OF SYMPTOMS: Please check any current symptoms that you may have.

Constitutional
___ Recent fevers/sweats
___ Unexplained weight loss/gain

Respiratory
___ Cough/wheeze
___ Coughing up blood

Skin
___ Rash
___ New or change in mole

___ Unexplained fatigue/weakness

Eyes
___ Change in vision

Gastrointestinal
___ Heartburn/reflux
___ Blood or change in bowel movement
___ Nausea/vomiting/diarrhea

Neurological
___ Headaches
___ Memory Loss
___ Fainting

Ear/Nose/Throat/Mouth
___ Difficulty hearing
___ Ringing in ears
___ Hay fever/allergies/congestion
___ Trouble swallowing

Genitourinary
___ Painful/bloody urination
___ Leaking urine
___ Nighttime urination
___ Discharge from penis
___ Concerns with sexual functions

Psychiatric
___ Anxiety
___ Stress
___ Sleeping Problems

Cardiovascular
___ Chest pains/discomfort
___ Palpitations

Musculoskeletal
___ Muscle/joint pain
___ Recent back pain

Blood/Lymphatic
___ Unexplained lumps
___ Easy bruising/bleeding

Endo
___ Cold/heat intolerance
___ Increase in thirst/appetite

In the past month, have you had little interest or pleasure in doing things, or felt down, depressed, or hopeless? Yes___ No ___

SURGICAL HISTORY: Please list all prior operations (with dates): _____

_____

_____

FAMILY HISTORY: Please indicate the current status of your immediate family members.

Please indicate family members (parent, sibling, grandparent, aunt, or uncle) with any of the following conditions:

Alcoholism: _____ *High Cholesterol:* _____

Cancer (specific type): _____ *Stroke:* _____

Heart Disease: _____ *High Blood Pressure:* _____

Depression/Suicide: _____ *Bleeding/Clotting Disorder:* _____

Genetic Disorder: _____ *Asthma/COPD:* _____

Diabetes: _____ *Other:* _____

SOCIAL HISTORY

Tobacco Use:

Cigarettes: Never___ Quit Date: _____

___Current Smoker: packs/day ____ # of yrs. ____

Are you interested in quitting? Yes ____ No ____

Other Tobacco: Pipe ___ Cigar ___

Snuff ___ Chew ___

***Caffeine Intake*:** None___ Coffee/Tea ____ cups/day

Weight:

Are you satisfied with your weight? Yes ___ No ___

Diet:

How would you rate your diet? Good ___ Fair___ Poor___

Do you take calcium supplements? Yes___ No___

Do you take a daily multivitamin? Yes ___ No ___

Alcohol Use:

Do you drink alcohol? No___ Yes ___ #drinks/week ____

Is your alcohol use a concern for you and others? Yes__ No___

Drug Use:

Do you use any recreational drugs? Yes___ No ___

Have you ever used needles to inject drugs? Yes___ No ___

Exercise:

Do you exercise regularly? Yes ___ No ____

What kind of exercise? _____

How long (minutes)? _____ How often? _____

If you do not exercise, why? _____

Have you completed a living will or a durable power of attorney for healthcare? _____

Sexual Activity:

Are you sexually active? Yes ___ No ___

Current sex partner is: Male ___ Female ___

Birth control method: _____

Have you ever had any sexually transmitted diseases (STD's)? Yes ___ No ___

Safety:

Do you use a bike helmet? Yes ___ No ___

Do you wear your seatbelt? Yes ___ No___

Is violence at home a concern? Yes___ No ___

Have you ever been abused? Yes ___ No ___

SOCIOECONOMICS:

Occupation: _____ Employer: _____

Years of education/highest degree: _____ Marital Status: Single _____ Partner/Married _____ Divorced ____

Widowed___ Other _____ Spouse/Partner's Name _____

Number of children/ages: _____ Who lives at home with you? _____

The Hormone & Wellness Center

PATIENT CHECKLIST FOR SYMPTOMS OF HORMONE IMBALANCE

Male Hormone Imbalance

Hot flashes ___ Apathy ___ Nervousness ___ Decreased libido ___Night sweats ___ Prostate problems ___ Sleep disturbances ___ Irritable ___ Foggy thinking ___ Fatigue ___ Decreased urine flow ___ Anxiety ___ Bone Loss ___ Increased urination ___ Headaches ___ Weight gain in hips ___ Depression ___

*Check which of these symptoms are troublesome and persist over time. For two or more symptoms, **Testosterone** and **DHEA Sulfate** testing is recommended.*

Decreased libido ___ Prostate problems ___ Decreased muscle mass ___ Burned out feeling ___ Decreased erections ___ Decreased mental sharpness ___ Thinning skin ___ Oily skin ___ Aches and pains ___ Fatigue ___ Increased joint pain ___ Decreased stamina ___ Aggression ___ Foggy thinking ___ Depression ___ Decreased urine flow ___ Irritable ___ Nervousness ___ Heart palpitations ___ Bone Loss ___ Increased urinary urge ___ Anxiety ___ Decreased flexibility ___

Adrenal Imbalance

Fatigue ___ Anxious ___ Hair loss ___ Chemical sensitivity ___ Weight gain in waist ___ Memory lapses ___ Increased facial hair ___ Stress ___ Decreased muscle mass ___ Acne ___ Depression ___ Increased body hair ___ Cold body temperature ___ Increased joint pain ___ Thinning skin ___ Headaches ___ Sugar cravings ___ Aches/pains ___ Elevated triglycerides ___ Decreased libido ___ Allergies ___ Irritable ___ Sleep disturbances ___

The Hormone & Wellness Center

Thyroid Function

Check which of these symptoms are troublesome and persist over time. Two or more symptoms are an indication of Thyroid Hormone (TSH, T3, T4, TPO Antibody) imbalances.

Fatigue ___ Low blood pressure ___ Decreased muscle mass ___ Bulging eyes ___ Goiter ___

Depression ___ Slow pulse rate ___ Thinning skin ___ Anxiety ___ Erratic behavior ___

Weight gain ___ Inability to lose weight ___ Memory lapses ___ Decreased sweating ___

Hair loss ___ Hair dry or brittle ___ Cold body temperature ___ Infertility problems ___

Panic attacks ___ Bone loss ___ Mood changes ___ Heart palpitations ___ Insomnia ___

Always feeling hot ___ Tremors in fingers ___ Swelling/puffy eyes or face ___ Hoarseness ___

Constipation ___ Thick tongue ___ Aches/pains ___ Decreased libido ___ Rapid weight loss ___

Sleep disturbances ___ Rapid heartbeat ___ Short attention span ___ Nails breaking or brittle ___

Male Andropause

Check which of these symptoms are troublesome and persist over time. Two or more symptoms are an indication of andropause and/or general male hormone imbalance.

Burned out feeling ___ Irritable ___ Insomnia ___ Increased urinary urge ___

Decreased mental sharpness ___ Decreased strength ___ Stress ___ Decreased urine flow ___

Decreased stamina ___ Decreased libido ___ Prostate problems ___ Infertility problems ___

Sleep disturbances ___ Hot flashes ___ Night sweats ___ Constipation ___ Irritability ___

Erectile Dysfunction ___ Weight gain in waist ___