The Smart Age

Patient Questionnaire & History

Full name: _____ Date: _____

Date of Birth: _____ Age: _____ Occupation: _____

Home address: _____ Zip Code: _____

Home phone: _____ Cell phone: _____ Work phone: _____

E-mail address: _____ May we contact you via e-mail? Y or N

How did you hear about us? _____ Referred by? _____

In case of emergency contact: _____ Relationship: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Primary care physician: _____ Phone Number: _____

Address: _____

Marital status (please circle one): Married Divorced Widow Single Living with Partner

*If we cannot contact you by the mean's you've provided above, we would like to know if we have your 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.

Spouse's name: _____ Relationship: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Social:

- 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

Habits:

- I smoke cigarettes and/or cigars _____x per day
- I drink alcoholic beverages _____x per week
- I drink more than 10 alcoholic beverages a week. Please circle: **Y** or **N**
- I use caffeine _____x per day

Symptoms

(please check all that apply)	Never	Mild	Moderate	Severe
Fatigue				
Dry Skin				
Insomnia				
Change in mood: Depression/anxiety				
Decreased sex drive/performance				
Loss of spontaneous morning erections				
Infrequent or absent ejaculations				
Shrinking testicles				
Weight gain/belly fat				
Breast development				
Declining mental ability/memory				
No result from ED medications				
Diminished strength and exercise tolerance				
Muscle shrinkage				
Joint ache or new arthritic symptoms				
Height decreased				
Rapid hair loss				
New migraine headaches				

Other Symptoms that may concern you:

_____

_____

_____

The Smart Age
Male Medical History Form

Any known drug allergies: _____

Have you ever had any issues with anesthesia? ○ Yes ○ No

If yes, please explain: _____

Medications you're currently taking: _____

_____

Current hormone replacement therapy: _____

Past hormone replacement therapy: _____

Nutritional/Vitamin supplements: _____

Surgeries, please list all: _____

Urological exam in the last year- Prostate exam and PSA: ○ Normal ○ Abnormal ○ N/A

Other pertinent information: _____

Preventative Medical Care:

- Prostate exam in the last year
- Bone Density exam in the last year

High Risk Medical/Surgical History:

- I have had testicular or prostate cancer
- I have an elevated PSA

Medical Illnesses:

- High blood pressure
- Heart bypass
- High cholesterol
- Hypertension
- Heart disease
- Stroke and/or heart attack
- Blood clot and/or pulmonary emboli
- Arrhythmia
- Any form of Hepatitis or HIV
- Auto immune disease
- Fibromyalgia
- Trouble passing urine- taking Flomax or Avodart
- Chronic liver disease (Hepatitis, Fatty Liver, Cirrhosis)
- Diabetes
- Thyroid disease
- Arthritis
- Depression/Anxiety
- Psychiatric disorder
- Cancer, please list type: _____ Year: _____

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Restrictions & Release of Personal Healthcare Information

Please list anyone that can be present during your exam and/or medical treatment:

1.) _____
2.) _____
3.) _____

Please list any person(s) that we may discuss your medical treatment or condition with:

1.) _____
2.) _____
3.) _____

Please list any person(s) that we are not to discuss your medical treatment or condition with:

1.) _____
2.) _____
3.) _____

We will need to contact you from time to time regarding appointments and/or your personal care. The information may confidential. Please check the method of contact in which we can use:

- o Home Telephone
- o Cell phone
- o Work line
- o Text message
- o E-mail

I understand all precautions will be taken to protect my privacy. I will notify this office in writing of any changes to this document.

Full name: _____ Date: _____

Signature: _____

The Smart Age
HIPPA Information & Consent Form

The Health Insurance Portability and Accountability Act (HIPPA) provides safeguards to protect your privacy. Implemtation of HIPPA requirements officially began on April 14th, 2003. Many of the policies have been in our practice for years. This form is a "friendly" version. A more complete text is posted here at 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. HIPPA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality and 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 mater 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, iMessage, SMS messaging, e-mail, US 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 HIPPA.

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

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

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

8.) 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 HIPPA Information Form and any subsequent changes in the office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ Date: _____

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Testosterone Pellet Insertion Consent Form

Bio-identical hormone pellets are concentrated hormones, biologically identical to the hormones you make in your own body prior to menopause. Testosterone was made in your testicles prior to "andropause". Bio-identical hormones have the same effects on your body as your own testosterone did when you were younger.

Bio-identical hormone pellets are made from soy and are FDA monitored, but not approved for female hormonal replacement. The pellet method of hormone replacement has been used in Europe, the US and Canada since the 1930's by select doctors in the United States, such as Dr. Gambrell and Dr. Lobo, both Endocrine/Gynecologists. Your risks are similar to those of any testosterone replacement but may be lower risk than alternative forms. During andropause, the risk of not receiving adequate hormone therapy can equal or outweigh the risks of replacing testosterone with pellets.

Risks of not receiving testosterone therapy after andropause include: Ateriosclerosis, elevation of cholesterol, obesity, loss of strength and stamina, generalized aging, osteoporosis, mood disorders, depression, arthritis, loss of libido, erectile dysfunction, loss of skin tone, diabetes, increased overall inflammatory processes, dementia and/or Alzheimer's disease and many other symptoms of aging. Testosterone pellet therapy is generally suggested for you after traditional methods for replacement have failed or if you seek more physiologic treatment for andropause. Urologic consultation or primary care doctor approval for this therapy should be obtained prior to consenting and written permission by your physician is **necessary** before beginning testosterone pellet replacement therapy.

Consent for Treatment: I consent to the insertion of testosterone pellets in either side of my hip. I have been informed that I may experience any of the complications to this procedure as described below. These side effects are similar to those related to traditional testosterone and/or estrogen replacement. Surgical risks are the same as for any minor medical procedure and are included in the list of overall risks below:

Bleeding, bruising, swelling, infection and pain, extrusion of pellets, hyper sexuality (overactive libido), lack of effect (lack of absorption), breast tenderness and swelling especially in the first three weeks (estrogen pellets only), increase in hair growth on the face, similar to pre-menopausal patterns: water retention (estrogen only), increased growth of estrogen dependent tumors (endometrial cancer, breast cancer), birth defects in babies exposed to testosterone during their gestation, growth of liver tumors (if already present), change in voice (which is reversable), clitoral enlargement (which is reversible). Testosterone therapy may increase one's hemoglobin and hematocrit or thicken one's blood. This problem can be diagnosed with a blood test. Thus, a complete blood count (Hemoglobin and Hematocrit) should be done at least annually. This condition can be reversed simply by donating blood periodically.

Benefits of Testosterone: Increased libido, energy, and sense of wellbeing. Increased muscle mass and strength and stamina. Decreased frequency and severity of migraine headaches. Decrease in mood swings, anxiety, and irritability. Decreased weight. Decrease in risk or severity of diabetes. Decreased risk of heart disease. Decreased risk of Alzheimer's and dementia. I have read and understand the above. I have been encouraged and have had the opportunity to ask any questions regarding pellet therapy. All my questions have been answered to my satisfaction. I further acknowledge that there may be risks of testosterone and/or estrogen therapy and that the risks and benefits of one or more of those listed above. I accept these risks and benefits and I consent to the insertion of hormone pellets under my skin. This consent is ongoing for this and all future pellet insertions I get with The Smart Age.

I understand that payment is due in full at the time of the service I receive. I also understand that it is my responsibility to submit any claim to my insurance company for possible reimbursement. I have been advised that most insurance companies do not consider pellet therapy to be a covered benefit and my insurance company may not reimburse me, depending on my coverage. I acknowledge that my provider has no contracts with any insurance company and is **not** contractually obligated to pre-certify treatment with my insurance company or answer any letter of appeal.

Print Full Name: _____ Date: _____

Signature: _____

The Smart Age
Insurance Disclaimer

Preventative medicine and bio-identical 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 and RN's or NP's, insurance does not recognize it as a necessary medicine, but it is considered like a plastic surgery (esthetic medicine) and therefore is not covered by health insurance in most cases.

Lotus Wellness and Health is no associated with any insurance companies, which means they are not obligated to pay for our services (blood work, consultations, insertions, injections, or pellets). We require full payment at the time of service, and we will provide a receipt showing that you have paid out of pocket. However, ***we will not*** communicate in any way with your insurance companies. The receipt is your responsibility and serves as evidence of your treatment.

We will ***not*** call, write, precertify, or make any contact with your insurance company. Any follow up letters from your insurance to us will be discarded. If we receive a check from your insurance company, we will not cash it, but instead we will immediately return it to the sender. Likewise, we will not be responsible for mailing it to you the patient. We will not respond to any phone calls, letters, or e-mails from your insurance company.

For patients who have access to a Health Savings Account, you may pay for your treatment with that credit or debit card. This is the best option for those patients who have an HAS as an option in their medical coverage.

Full name: _____ Date: _____

Signature: _____