HORMONES BY DESIGN
FEEL BETTER FROM DAY ONE

PATIENT INFORMATION

EMAIL:_____

MARITAL STATUS: [ ]MARRIED [ ]SINGLE [ ]DIVORCED [ ]WIDOWED

NAME:

_____
(FIRST) (MIDDLE) (LAST)

STREET:_____

CITY:_____STATE:_____ZIP CODE:_____

DOB: _____

PHONE: _____[ ]Home [ ]Work [ ]Cell

PHONE: _____[ ]Home [ ]Work [ ]Cell

PRIMARY CARE PHYSICIAN:_____

PATIENT EMPLOYMENT

[ ]Employed [ ]Retired [ ]Unemployed [ ]Other

EMPLOYER:_____

EMERGENCY CONTACT

_____

Relationship_____Phone:_____

Signature_____Date_____

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Male New Patient Paperwork

Name: Insurance: Age: Date:

Drug/Food Allergies: Reaction:

Reason for Visit:

Medications:

History of surgery? Yes No If yes, what type & when?

Personal Medical History:

Asthma	Yes	No	High Cholesterol	Yes	No
Diabetes	Yes	No	Hypertension	Yes	No
Heart Disease	Yes	No	Rheumatic Fever	Yes	No
Blood Clot	Yes	No	Kidney Disease	Yes	No
Thyroid	Yes	No	Stroke	Yes	No
Hepatitis	Yes	No	Blood Transfusion	Yes	No
Depression	Yes	No	Domestic Violence	Yes	No
Major Accident	Yes	No	Cancer	Yes	No
			Type:		

Family Medical History:

Diabetes	Yes	No	Father/Mother/Sibling/Other:
Hypertension	Yes	No	Father/Mother/Sibling/Other:
Heart Disease	Yes	No	Father/Mother/Sibling/Other:
Lung Disease	Yes	No	Father/Mother/Sibling/Other:
Kidney Disease	Yes	No	Father/Mother/Sibling/Other:
Endocrine Disorder	Yes	No	Father/Mother/Sibling/Other:
Blood Abnormality	Yes	No	Father/Mother/Sibling/Other:
Malignancy	Yes	No	Father/Mother/Sibling/Other:

Social History:

Your Occupation:

Marital Status: Married Single Widowed Divorced

Partner's Name:

Smoking:	Yes	No	Amount:
Alcohol:	Yes	No	
Drugs:	Yes	No	

History of preventative care:

Routine Physical	Yes	No	Last Exam/Scheduled:
Colonoscopy	Yes	No	Last Exam/Scheduled:

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SYMPTOMS-Male

Name:_____Date:_____

	I Feel Bad--1									I Feel Great--10
Sleep	1	2	3	4	5	6	7	8	9	10
Anxiety	1	2	3	4	5	6	7	8	9	10
Sex Drive	1	2	3	4	5	6	7	8	9	10
Energy AM	1	2	3	4	5	6	7	8	9	10
Energy PM	1	2	3	4	5	6	7	8	9	10
Muscle weakness	1	2	3	4	5	6	7	8	9	10
Muscle Loss	1	2	3	4	5	6	7	8	9	10
Foggy Thinking	1	2	3	4	5	6	7	8	9	10
Mood Swings	1	2	3	4	5	6	7	8	9	10
Weight Gain	1	2	3	4	5	6	7	8	9	10

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CONSENT TO TREAT & NOTICE OF OFF-LABEL USE

SAFETY OF HORMONE REPLACEMENT & OFF-LABEL DRUG USE

What is considered off-label drug/prescription use?

1. It is considered off-label use/alternative medicine if you are on any compounded form of medication. Please note that compounded medications do not meet FDA approval and therefore are considered off-label.
2. It is considered off-label use/alternative if you are on a medication which is being used outside of the medication labeling offered by the package insert.

Drug labels are specific to the disease they treat and therefore if the medication is used to treat a disease that is not specified in the label, then the agent is being used off-label. Additionally, any change to the approved dose, frequency or route of administration would constitute an off-label use.

The use of off-label medications is common practice among the medical community and while we are not legally required to obtain a signed written consent it is the belief of this practice that the patient be fully aware of the current treatment plan recommended including its risks, benefits and alternatives to your plan of care. Remember that even over the counter medications carry risks when taken. It is our belief that the treatment of hormone deficiencies can be of great benefit in improving quality of life

Medications and supplements which may be used off-label or as alternative medicine can include but are not limited to the following: armour thyroid, estriol, estradiol, progesterone, DHEA, and/or testosterone via pellets, injections or in compounded formulations. The use of supplements may also be used in an effort to help improve conditions and or symptoms that you may have presented with during your initial consultation and throughout the course of your visit.

If you experience any side effects associated from current prescribed medications please call the office immediately. If it is after usual business hours and you should have severe side effects please proceed to the nearest emergency room or urgent care facility for appropriate treatment.

While hormone therapy will not cause cancer, the use of hormones could potentially make an estrogen and/or progesterone positive cancer grow. Most breast cancers fall into this category.

As a patient you have the right to refuse any off-label use of the medication being prescribed. You also have the right to ask questions regarding the current treatment plan as well as alternatives to what is being prescribed. If you have any questions or concerns please make sure to discuss with your provider during your consultation and any future visits.

MALE PATIENTS DESIRING HORMONE REPLACEMENT

The reasonable alternatives to this treatment have been explained to me and they include:

1. Leaving the hormone levels as they are.
2. Treating age related diseases as they appear.
3. Using pharmaceutical agents that are not bio-identical in nature.

Possible side effects for men on testosterone replacement are: acne, persistent erections, unwanted hair growth, enlargement of the prostate, enlargement of breast tissue, testicular atrophy (shrinking); and increased risk of heart attack, stroke and other cardiovascular problems.

Contraindications: Do not use hormone replacement if you have a known history of reproductive system related cancers such as prostate cancer. Exceptions include reproductive system responsive cancer which has been under remission for over 5 years.

_____(Initial) I understand the possible treatments and side effects

ALL PATIENTS: OBLIGATIONS & REPRESENTATIONS

Any questions I have regarding this treatment have been answered to my satisfaction. I will comply with the recommended dose and methods of administration. I also agree to participate in the initial and subsequent blood testing as required to monitor my hormone levels.

I have disclosed accurate and true information regarding my medical history, medications, and surgeries.

I certify that I am under the regular care of another physician for all other medical conditions. I will consult my primary care physician(s) for any other medical services I may require. I understand that this is a specialized practice. I also understand that I will continue under the care of my other physician(s) for any on-going medical condition as well as for any medical consultation that I may need.

I assume full liability for any adverse effects that may result from the non-negligent administration of the proposed treatment. I waive any claim in law or equity for redress of any grievance that I may have concerning or resulting from the therapy, except as that claim pertains to negligent administration of the therapy.

I fully understand the nature and purpose of portions of the aforementioned treatment may be considered experimental because of the lack of adequate scientific evidence or peer-reviewed publications supporting the underlying premise of bio-identical hormone replacement therapy and that such therapy might even be considered by some medical professionals to be medically unnecessary because it is not aimed at treating a particular disease.

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 also understand there are possible benefits associated with this therapy but that no guarantee has been made to me regarding the outcomes of this treatment. I also understand that the benefits derived from antioxidant therapy, hormone therapy and drugs that alter hormone levels will cease or reverse if the therapy is discontinued.

ALL PATIENTS: CONSENT

I hereby authorize my physician to evaluate and treat the conditions I specified above. I understand that my physician may be assisted by other health professionals, as necessary, and agree to their participation in my care as it relates to the evaluation and treatment of the conditions this Consent to Treat covers. I am competent to sign this Consent to Treat and have done so of my own free will.

_____

Printed Name of Patient Signature of Patient

_____

Signature of Witness Date

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NOTICE OF HEALTH INFORMATION PRACTICES ACKNOWLEDGEMENT FORM

I acknowledge that I have received the Notice of Health Information Practices of Hormones by Design and this notice describes how medical information about me may be used and disclosed and how to get access to this information.

I understand that the organization reserves the right to change its notice and practices and, prior to implementation, will mail a copy of any revised notice to the address I've provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restriction requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I wish to have the following restriction to the use or disclosure of my health information:

_____

_____

PATIENT NAME (PRINTED)

_____

SIGNATURE DATE

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Authorization to Release Protected Health Information

***Patients: Please use this form to list any family members or additional doctors that you would like us to be able to discuss/share your medical information with. For example, if you want us to be able to share test results with your spouse you must fill out this form. Please print additional copies of this form for each individual or doctor.

Patient Name: _____ DOB: _____
Address: _____
_____

I hereby authorize _____ to release to:
Name: _____ Relationship: _____
Address: _____ Phone: _____
_____

The following information as indicated below:

{ } Complete Medical Record
{ } Lab Reports
{ } Operative Reports
{ } X-Rays/Imaging Studies
{ } Discharge Summary
{ } Other (specify) _____

I ___ **do**___ **do not** wish to have information about HIV/AIDS released under this authorization.
I ___ **do** ___**do not** wish to have information about sexually transmitted diseases released under this authorization.
I ___ **do** ___**do not** wish to have mental health records released under this authorization.
I ___ **do** ___**do not** wish to have information about drug/alcohol abuse treatment released under this authorization

The purpose for release of the above information is indicated below:

{ } At my request (patient only)
{ } Other (specify) _____

I understand this consent is voluntary and that I may revoke this authorization at any time (except to the extent that action based on this consent has already been taken) by written, dated, and signed communication to this office. This consent will expire in one year from date signed, unless otherwise stated as follows: _____

Each request for release of protected health information requires a separate authorization.

_____ _____
Signature of patient Date Signed

_____ _____
Signature of parent, guardian, or legal representative Witness

Verbal Consent requires signature of two witnesses:

_____ _____
Signature of Witness Date

_____ _____
Signature of Witness Date

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Patient Handbook

Welcome!

This handbook should help you discover how we differ from a traditional medical practice and outlines our office policies. Please feel free to ask our front desk staff if you have any questions.

When You Arrive

- When you first arrive, please register with the receptionist. You will be given an update sheet to fill out at every visit. This update sheet will need to reflect your current symptoms & any medication changes, etc.

When You Are Late for an Appointment

- Your time is valuable, and so is the doctor's/nurse practitioner's.
- Please be prompt.
- If you arrive 10 minutes or more after your scheduled appointment time, your appointment will have to be rescheduled.

Canceling Your Appointment

- Please give us 24 hours advance notice so that we may offer that appointment to someone on our waiting list.
- Unlike other medical practices, we do not charge a fee when patients fail to show up for an appointment. However, after three no-shows without notification, we will be forced to release you from our practice. We tend to have a full schedule every day. Late and missed appointments disrupt patient flow and unnecessarily prevent other patients from being able to schedule appointments during those missed slots.
- If you are a new patient and you do not show up for 2 consecutive appointments, and you do not call to cancel, you will be released from the practice.

When You Need Us After Hours

- When you call our office after hours, you will be directed to our answering service or voice mail.
- If you are experiencing a medical emergency or you believe you are experiencing a life-threatening situation, call 911 immediately, or go to the emergency department of your nearest hospital.
- If your urgent medical need is not life threatening, and it is during normal business hours, please call the office. We will help you determine the best plan of care.

Lab Testing

- We know that you want to know the results of your lab tests as soon as you can. Our office policy is that all patients must make a follow-up appointment with the doctor or Nurse Practitioner to go over lab results & determine a plan of care.

Prescriptions

- When you need a prescription refilled, contact your pharmacy. The pharmacy will notify our office via fax.
- For all patients on hormone or thyroid therapy, our office requires labs at least every 6 months in order to maintain refills.
- Please do not allow yourself to run out of medication. Most of the medications that our office prescribes are specialty or compounded and it can take several days for your pharmacy to fill your prescription.

Thank you for choosing our practice for your healthcare needs!
I have read and agree to the above office policies. Patient Name: _____

Signature: _____ Date: _____

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Consent for E-mail & Referral Source

Please fill in your email below if you would like to join our email list.

- The e-mail list will include educational updates to help improve your health.
- We will never share your information with a third party.

Email:_____

Name:_____

Signature:_____

Date:_____

Referral Source

HOW DID YOU HEAR ABOUT US?

[ ] INTERNET SEARCH--WHICH SEARCH ENGINE?_____

[ ] DIRECT MAILING_____

[ ] DR. REFERRAL—WHICH DR?_____

[ ] FRIEND

[ ] FAMILY

[ ] IN-OFFICE (ONE OF OUR EMPLOYEES)

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Consent for Appointment Reminders

We now have the ability to email and/or text you, appointment reminders. If you would like to receive this feature please read and sign the consent below.

I consent to receive text messages from Hormones by Design on my cell phone and any number forwarded or transferred to that number. The cell phone number that I authorize to receive text messages for appointment reminders is:

Cell Phone Number: _____

I consent to emails, to receive appointment reminders as stated above. The email that I authorize to receive email messages for appointment reminders
is:_____.

As of now, appointment reminders are sent one week, and then one day, in advance of your scheduled appointment.

I understand that this request to receive emails and/or text messages will apply to all future appointment reminders unless I request a change in writing.

Printed Name: _____Date: _____

Signature: _____