Elite Health and Wellness Center

PATIENT QUESTIONNAIRE & HISTORY

Name: _____ Date: _____

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

Home address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

May we send messages via text regarding apts to your cell/email? Yes_____ No_____

May we send messages via text to your cell/email? Yes_____ No_____

May we send messages via email regarding your Radiology & Lab Orders ? Yes___ No___

Primary care physician's name: Phone: _____

Address: _____

Marital status (check one): Married Divorced Widow Living with partner Single

Pharmacy: _____ Pharmacy Address: _____ Phone: _____

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: _____

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-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.

Activity Level: Low(Workout 0-1 day a week) _____ Average (Workout 2-3 day a week) _____High(Workout more then 3 days a week)_____

Elite Health and Wellness Center

8980 S US HWY 1, Suite 106
Port Saint Lucie, FL 34952

P: (772) 777-8233 F: (772) 673-7710
www.elitehealthandwellnesscenter.com

PATIENT INFORMATION

Name:_____ Date:_____

Date of Birth:_____ Age:_____ Weight:_____ Height:_____

PATIENT QUESTIONS

Currently trying to conceive?	☐ Yes ☐ No
Desire to conceive in the future?	☐ Yes ☐ No
Is patient on a 5-alpha reductase inhibitor?	☐ Yes ☐ No
Is the patient on a PDE-5 Inhibitor (Cialis, Viagra, Etc.)	☐ Yes ☐ No
Is the patient on any other testosterone boosting medication (Clomid, HCG, etc.)?	☐ Yes ☐ No
Is the patient currently utilizing BHRT or HRT?	☐ Yes ☐ No
If yes, select types of Hormones:	☐ Testosterone ☐ Thyroid
List name and dose of hormone(s):	_____
Is the patient currently on statins?	☐ Yes ☐ No
Is the patient a smoker?	☐ Yes ☐ No
Is the patient currently on oral nitrates?	☐ Yes ☐ No

MEDICAL HISTORY

Select all that apply:

Fertility:

☐ Patient Wants to Maintain Fertility

Cardiovascular Conditions:

☐ Heart Attack or Stroke (within last 6 months)
☐ DVT or Blood Clot (within last 6 months)
☐ Hypertension
☐ Hyperlipidemia
☐ Obstructive Sleep Apnea
☐ Patient Takes Anticoagulant Medication
☐ Atrial Fibrillation
☐ Tachycardia

Cancer:

☐ Breast Cancer
☐ Active Prostate Cancer or History of Prostate Cancer
☐ Thyroid Cancer or History of Thyroid Cancer
☐ Meningioma
☐ Polycythemia Vera (PV)
☐ Except for Basal Cell Carcinoma any Other Cancers?

Neurological Conditions:

☐ Epilepsy or Seizure Disorder

Endocrine and Metabolic:

☐ Diabetes Type 2 or Insulin Resistance
☐ Hyperthyroid
☐ Hypothyroid
☐ Multiple Endocrine Neoplasia Type-2

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MEDICAL HISTORY

Autoimmune Conditions:

- ☐ Diabetes Type 1
- ☐ Hashimoto's Thyroiditis
- ☐ Graves' Disease
- ☐ Rheumatoid Arthritis
- ☐ Multiple Sclerosis
- ☐ Systemic Lupus (Erthematosus)
- ☐ Psoriasis
- ☐ Positive ANA
- ☐ IBS (Irritable Bowel Syndrome)
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis

Organ Specific Conditions:

- ☐ Liver Disease or History of Liver Disease
- ☐ Kidney Disease or History of Kidney Disease
- ☐ LAM (Lymphangioleimyomatosis)
- ☐ Osteoporosis or Osteopenia
- ☐ Prostate Enlargement (BPH)
- ☐ HIV
- ☐ Hepatitis
- ☐ Hemochromatosis
- ☐ Pancreatitis or History of Pancreatitis
- ☐ History of or Gall Bladder Disease

SYMPTOMS AND CONCERNS

Select all that apply:

- ☐ Acne
- ☐ Erectile Dysfunction (ED)
- ☐ Decreased Libido
- ☐ Decreased Desire
- ☐ Inability To or Delayed Orgasm
- ☐ Weight Gain
- ☐ Decreased Muscle Mass
- ☐ Difficulty Sleeping
- ☐ Urinary Incontinence
- ☐ Dry or Flaking Skin
- ☐ Lack of Energy (Fatigue)
- ☐ Decrease in Strength or Endurance
- ☐ Decrease in Work Performance
- ☐ Frequent Urinary Tract Infection
- ☐ Brittle Nails
- ☐ Thinning Eyebrows
- ☐ Hair Thinning
- ☐ Cold Hands or Feet
- ☐ Mind Racing at Bedtime
- ☐ Mood Swings
- ☐ Gynecomastia
- ☐ Abdominal Obesity

Family History: (Please Circle)

Heart Disease Diabetes Osteoporosis Dementia/Alzheimer Disease Cancer :_____

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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: _____

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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.

Initial Office Visit Consultation Fee	$175
Female/Male pellet insertion fee	$399/$750

We accept the following forms of payment:
All major credit cards, Personal Checks & Cash
~~We DO NOT accept Insurance~~

Print name: _____

Signature: _____ Date: _____