BALANCE HORMONE CENTER

Female Patient Information

Full Name: _____ Birth Date: ____ / ____ / _____

Home Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Cell Phone: _____

Primary Language: _____

Marital Status: S M D W Gender: M F Other: _____

As a convenience to our patients, we offer appointment reminders through phone calls and text messages. Would you like to be set up on automatic text reminders? [ ] Yes [ ] No

If yes, who is your cell phone provider? _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship: _____

Phone Number: _____

PREFERRED PHARMACY & LOCATION:

_____

Primary reason for visit: _____

How did you hear about Balance Hormone Center? _____

I hereby authorize the staff of Balance Hormone Center to provide such medical services, either regular or emergency, not limiting to Hormone Replacement or Weight Loss, as may be determined by my physician to be in the patient's (me or my dependent, if signing for minor) best interest. I authorize payment of medical benefits to Balance Hormone Center. I agree that all charges for medical services rendered that are not directly paid by my insurance will be my responsibility. In the event it becomes necessary for Balance Hormone Center to forward my account balance to an outside collection agency, I understand I will also be responsible for paying a up to a $30 collection fee. I hereby authorize Balance Hormone Center to release the necessary information regarding me to my health insurance plan in order to complete and process my insurance claims.

Signature: _____ **Print:** _____ **Date:** _____

Please indicate symptoms you are currently experiencing:

[□] Night Sweats	[□] Hot Flashes	[□] Painful Intercourse
[□] Vaginal Dryness	[□] Difficulty Sleeping	[□] Difficulty Concentrating
[□] Mood Swings	[□] Decrease Sex Drive	[□] Muscle and/or Joint Pain
[□] Fatigue	[□] Foggy Thinking	[□] Anxiety

MEDICAL HISTORY

Please check those which you have or have had

[□] Arthritis	[□] Blood Disorder	[□] Cancer	[□] Diabetes
[□] ENT Problems	[□] Gastrointestinal	[□] Urinary/Prostate	[□] Heart Disease
[□] High Blood Pressure	[□] High Cholesterol	[□] Kidney Problems	[□] Liver Problems
[□] Lung Problems	[□] Musculoskeletal	[□] Stroke	[□] Seizure
[□] Psychiatric	[□] Skin Disease	[□] Thyroid	[□] Sleep Apnea

Please check if you have had any of the following surgeries:

[□] Hysterectomy	[□] Gallbladder	[□] Tonsillectomy	[□] Hernia Repair
[□] Joint Surgery	[□] Breast Biopsy	[□] Uterine Biopsy	[□] Appendectomy
[□] C-Section	[□] Breast Augmentation	[□] Wisdom Teeth	

MENSTRUAL HISTORY

[□] Currently have regular menstrual cycles	[□] Hysterectomy
[□] Ablation	[□] Menopause

PREGNANCY HISTORY

Are you currently, or do you think you might be pregnant? [□] Yes [□] No

Date of last menstrual period? _____

# of Pregnancies _____ Miscarriages _____ Live Births _____

OVER THE LAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY THE FOLLOWING PROBLEMS? Circle a choice that fits best

1. Little interest or pleasure in doing activities.

Not at all Several Days More than half of the days Nearly every day

2. Feeling down, depressed or hopeless.

Not at all Several Days More than half of the days Nearly every day

PREVENTATIVE CARE

	(Circle One)
Last Mammogram _____ Abnormal?	**Y** or **N**
Any history of abnormal mammogram(s)?	**Y** or **N**
Last Pap Smear _____ Abnormal?	**Y** or **N**
Any history of abnormal Pap Smear?	**Y** or **N**

FAMILY MEDICAL HISTORY

Father Age ____ Medical Conditions _____
Mother Age ____ Medical Conditions _____
Sibling Age ____ Medical Conditions _____
Sibling Age ____ Medical Conditions _____
Sibling Age ____ Medical Conditions _____
Sibling Age ____ Medical Conditions _____
Maternal Grandfather Age ____ Medical Conditions _____
Maternal Grandmother Age ____ Medical Conditions _____
Paternal Grandfather Age ____ Medical Conditions _____
Paternal Grandmother Age ____ Medical Conditions _____

SOCIAL HISTORY

[□] Tobacco ____ Packs/Day **[□]** Caffeine ____ Cups/Day **[□]** # of Children ____
[□] Alcohol ____ Drinks/Week **[□]** Exercise ____ Days/Week **[□]** Desire More Children
[□] Recreational Drugs

OCCUPATION: _____

Please list any known drug and/or food allergies:

_____

_____

_____

Please list all current medications you are taking and the dosage:

[□] ADD	**[□]** Blood Pressure	**[□]** Statin
[□] Antidepressant	**[□]** Diabetic	**[□]** Steroid
[□] Antacid	**[□]** NSAID	**[□]** Thyroid

Other:_____

Please list all current supplements you are taking and the dosage:

[□] Calcium	**[□]** Hormone	**[□]** Sleep
[□] Fiber	**[□]** Iron	**[□]** Sport
[□] Fish Oil	**[□]** Joint	**[□]** Vitamin D
[□] Hair/Skin/Nail	**[□]** MultiVitamin	**[□]** Weight Loss

Other:_____

I hereby certify that the previous questions were answered accurately.
I understand that providing incorrect information can be dangerous to my health.

Patient/Guardian Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES: Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Balance Hormone Center, PLLC. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change, and we have reserved the right to change it. If we change our notice, you may obtain a copy of the revised notice by contacting our office. If you have any questions about our Novice of Privacy Practices, please contact: Balance Hormone Center 3530 S Val Vista Drive, Suite 214 Gilbert, AZ 85297 480-718-9960

I acknowledge receipt of the Notice of Privacy Practices of Balance Hormone Center, PLLC

Signature: _____ (Patient) **Date:** _____
OR: I acknowledge receipt of the Notice of Privacy Practices of Balance Hormone Center, PLLC on behalf of _____.

Signature: _____ (Guardian) **Date:** _____

PLEASE INDICATE SYMPTOMS YOU ARE CURRENTLY EXPERIENCING:

GENERAL: [☐] Abnormal Weight Gain [☐] Decreased Appetite [☐] Night Sweats
[☐] Abnormal Weight Loss [☐] Appetite Change [☐] Fatigue

EYES: [☐] Blurry Vision [☐] Visual Disturbances
[☐] Double Vision

CARDIOVASCULAR: [☐] Chest Pain/Pressure [☐] Palpitations
[☐] Fainting [☐] Dizziness

RESPIRATORY: [☐] Shortness of Breath [☐] Wheezing
[☐] Coughing

GI: [☐] Heartburn [☐] Persistent Nausea [☐]Vomiting
[☐] Abdominal Pain [☐] Swallowing Difficulties

GENITOURINARY: [☐] Urinary Frequency [☐] Pain with Urination [☐] Urinary Urgency
[☐] Night Time Urination [☐] Urinary Hesitancy [☐] Blood in Urine

NEUROLOGIC: [☐] Headaches [☐] Tingling [☐] Weakness
[☐] Numbness [☐] Poor Balance [☐] Foggy Thinking
[☐] Decreased Mental Focus

ENT: [☐] Hearing Loss [☐] Ear Pain
[☐] Dizziness [☐] Nasal Congestion

MUSCULOSKELETAL: [☐] Joint Pain [☐] Swelling [☐] Muscle Pain
[☐] Decrease in Strength [☐] Decrease in Endurance
[☐] Decrease in Muscle Size [☐] Decrease in Performance

SKIN: [☐] Rashes [☐] Acne
[☐] Suspicious Skin Lesions

PSYCHIATRIC: [☐] Anxiety [☐] Insomnia
[☐] Depression [☐] Irritability

ENDOCRINE: [☐] Hot/Cold Intolerance [☐] Excessive Thirst

Female Testosterone and Estradiol Hormone Pellet

General -- Bio-identical hormone pellets are comprised of naturally derived concentrated hormones. These hormones are designed to be biologically identical to the hormones a woman makes in her own body prior to menopause, including estrogen and testosterone which are made in the ovaries and adrenal gland. Bio-identical hormones have the same effects on the body as one's own estrogen and testosterone did when the woman was younger without the monthly fluctuations (ups and downs) of menstrual cycles.

Birth Control -- Patients who are pre-menopausal are advised to continue reliable birth control while participating in pellet hormone replacement therapy. Testosterone is listed as category X (will cause birth defects) and cannot be given to pregnant women. Birth Control Method is:

[ ] Abstinence [ ] Hysterectomy [ ] Menopause
[ ] Birth Control Pill [ ] IUD [ ] Tubal Ligation
[ ] Other _____

Benefits and Risks -- I have been told I may have testosterone inserted under my skin to achieve a steady delivery of natural testosterone hormone into my blood system. The potential benefits of testosterone include a possible increase in my bone density, short term memory, protect against Alzheimer's, increase in my energy, my libido, and my sense of well-being. I may, also, see testosterone decreasing the frequency and severity of my headaches. I have, also, been told that I may have estradiol pellet (s) inserted under my skin to also achieve a steady state of estradiol in my body. The potential benefits of estradiol include possible elimination of my mood swings, anxiety, and irritability, cardiovascular protection, protect from developing colon cancer, and brain dysfunction.

The above potential benefits come with some risks; Pellet insertion is not the usual and customary means of hormone replacement. In cases of excessive consumption of synthetic testosterone by males, adverse conditions included heart problems and elevated cholesterol. Pellet therapy is low-dose, non-oral, and uses natural testosterone, and is not associated with such problems.

In a rare number of patients, the body will convert testosterone to DHT which can cause acne or hair loss. The estradiol dosage that I may receive can aggravate fibroid(s) or polyps, if they exist, causing bleeding.

Side effects or complications are substantially more rare than in the case of non-bioidentical hormones, but may include: bleeding, infection and pain at the insertion site, lack of effect (from 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 or breast cancer); birth defects in babies exposed to testosterone during their gestation; growth of live tumors, if already present; change in voice -- which is reversible; clitoral enlargement - which is reversible.

Charges -- I understand there is a charge which varies depending on the number of pellets I may receive. The precise amount is to be determined by my medical provider. I understand payment is due in full at the time of service.

My signature below certifies that I have read and understood the above as well as my acknowledgement that I have been encouraged to ask any questions regarding pellet therapy and all my questions have been answered to my satisfaction. I, also, acknowledge that the risks and benefits of this treatment have been explained to me and that I may experience one or more of the complications listed above. I accept these risks and benefits as well as consent to the insertion of hormone pellets under my skin

Patient Name: _____ **Date of Birth:** _____

Patient Signature: _____ **Date**: _____

HIPAA COMPLIANCE PATIENT CONSENT FORM

Our notice of Privacy Practices provides information about how we may use or disclose protected health information.

This notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature you have reviewed our notice before signing this consent.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are required to honor this agreement (except under an emergency situation). The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations
- This practice reserves the right to change the privacy policy as allowed by law.
- This practice has the right to restrict the use of the information.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- This practice may condition receipt of treatment upon the signing of this consent.

May we phone, email or send a text to you to confirm appointments? [ ] Yes [ ] No

May we leave a message on your answering machine? [ ] Yes [ ] No

I authorize that the following individual(s) may have ongoing access to my protected Health Information:
Printed Name: _____ Phone Number: _____
Relationship: _____

Printed Name:_____ Phone Number: _____
Relationship: _____

Printed Name:_____ Phone Number: _____
Relationship: _____

This consent was signed by: _____ (Printed Name)

SIGNATURE: _____ DATE: _____

FINANCIAL RESPONSIBILITY AGREEMENT

I understand the self-pay initial consult fee for my hormone replacement therapy visit with Balance Hormone Center is $135 (effective 02.01.2024). This charge does not include any treatment cost, pellets, injections, supplements, pharmacy medications, or lab testing. I understand the self-pay follow-up visit fee for my hormone replacement therapy visit with Balance Hormone Center is $75 (effective 02.01.2024). This charge does not include any treatment cost, pellets, injections, supplements, pharmacy medications, or lab testing.

I understand that if I have provided Balance Hormone Center with my insurance information that I will be charged according to the contracted rates between Balance Hormone Center and my insurance company. I understand and agree that I will be financially responsible for any and all charges for services rendered and not paid by my insurance. This includes any medical services or visits, hormone replacement therapy, weight loss treatment, preventative exam/physical, lab or diagnostic testing, and any other services performed by the physician or the physician's staff.

I understand and agree that it is my responsibility and not the responsibility of the physician or staff to know if my insurance will pay for such medical service(s), hormone replacement therapy, weight loss treatment, preventative exam/physical, lab, or diagnostic testing, or any other service performed by the physician or the physician's staff.

I understand and agree that it is my responsibility to know if my insurance has any deductible, co-pay, co-insurance, out-of-network, usual and customary limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment.

I understand and agree that it is my responsibility to know if the physician that I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician I am seeing is not, it may result in claims being denied or higher out-of-pocket expenses to me. I understand this and agree to be financially responsible and make full payment.

I hereby authorize payment of benefits to go directly to **BALANCE HORMONE CENTER** for services rendered. Authorization is hereby granted to release information contained in my medical record to my insurance company or its employee’s agents as may be necessary to process and complete my medical insurance claim(s). I further understand should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses, if any. The duration of this authorization is indefinite and continues until revoked in writing.

Printed Name: _____ Signature: _____ DATE: _____

CANCELLATION/ NO SHOW AGREEMENT

At Balance Hormone Center, we do our best to get our patients seen in a timely fashion. In return, we ask that you show up on time for your appointment. If you show up more than 10 minutes past your appointment time, you will be forced to reschedule. We do understand there are times you may need to reschedule your office visit/ procedure. If you cancel/reschedule your visit with sufficient notice, this allows us to fit other patients in that may need to be seen for their health concerns.

Effective November 1, 2023

If you have an appointment for an office visit (New patient or Follow up visit), in order to avoid a cancellation charge, you must cancel your appointment at least 24 hours/ 1 business day prior to your appointment time. This means if your appointment is scheduled on a Monday it would need to be canceled no later than Friday. Otherwise, you will incur a $25 charge. If you do not show for your appointment or show up past your scheduled appointment time, including the grace period listed above, you will incur a No Show fee of $40.

I have read, understood and agreed to the agreement described above.

Printed Name: _____ **Signature:** _____ **DATE:** _____