## Male 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 $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 CHECK WHICH PERTAIN TO YOUR HISTORY/SYMPTOMS**
Concerns/reason for visit:

[□] Fatigue [□] Erectile Dysfunction [□] Decreased Libido
[□] Weight Gain [□] Weight Loss [□] Decreased Muscle Mass
[□] Depression [□] Other ________________

Symptoms Began: ______________ Months or Years Ago: ____________

Severity of Symptoms [□] Mild [□] Moderate [□] Severe

## MUSCULOSKELETAL

| | (Circle One) |
|---|---|
| Decrease in muscle size, strength, or tone? | **Y** or **N** |
| Decrease in endurance or performance? | **Y** or **N** |

## MENTAL FUNCTION

| | **None** | **Mild** | **Moderate** | **Severe** |
|---|---|---|---|---|
| Fatigue, especially in the afternoon | [□] | [□] | [□] | [□] |
| Decreased mental focus | [□] | [□] | [□] | [□] |

## SEXUAL FUNCTION

| | | | | |
|---|---|---|---|---|
| Morning Erections | [□] | [□] | [□] | [□] |
| Decreased Libido | [□] | [□] | [□] | [□] |
| Erectile Dysfunction | [□] | [□] | [□] | [□] |

## 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

## SURGICAL HISTORY

[ ] Heart [ ] Head/Neck [ ] Lung [ ] Spine
[ ] Abdominal [ ] Bone/Joint [ ] Pelvic

**Past History of Hormone Replacement (testosterone injections, etc.)** **Y** or **N**

If YES, previous testosterone level ___________ Dates ________________________________

Dose ___________________ Results ______________________________________________

**Have you had an annual physical exam done in the last 12 months?** **Y** or **N**

## 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

## FAMILY MEDICAL HISTORY

Father Age ____ Medical Conditions ______________________________________________
Mother Age ____ Medical Conditions ______________________________________________
Brother or Sister Age ____ Medical Conditions ________________________________________
Brother or Sister Age ____ Medical Conditions ________________________________________
Brother or Sister Age ____ Medical Conditions ________________________________________
Brother or Sister 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
[] Antidepressant
[] Antacid
[] Blood Pressure
[] Diabetic
[] NSAID
[] Statin
[] Steroid
[] Thyroid

Other:_______________________________________________________________________

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

[] Calcium
[] Fiber
[] Fish Oil
[] Hair/Skin/Nail
[] Hormone
[] Iron
[] Joint
[] MultiVitamin
[] Sleep
[] Sport
[] Vitamin D
[] 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 | [☐] Night Sweats | [☐] Decreased Appetite |
| | [☐] Abnormal Weight Loss | [☐] Appetite Change | [☐] Fatigue |
| **EYES:** | [☐] Blurry Vision | [☐] Visual Disturbances | |
| | [☐] Double Vision | [☐] Other: __________ | |
| **CARDIOVASCULAR:** | [☐] Chest Pain/Pressure | [☐] Palpitations | [☐] Dizziness |
| | [☐] Fainting | [☐] Other: ___________ | |
| **RESPIRATORY:** | [☐] Shortness of Breath | [☐] Wheezing | |
| | [☐] Coughing | [☐] Other: __________ | |
| **GI:** | [☐] Persistent Nausea | [☐] Heartburn | [☐] Difficulty Swallowing |
| | [☐] Abdominal Pain | [☐] Vomiting | [☐] Other: __________ |
| **GENITOURINARY:** | [☐] Urinary Frequency | [☐] Urinary Urgency | [☐] Blood in Urine |
| | [☐] Night Time Urination | [☐] Urinary Hesitancy | |
| | [☐] Pain with Urination | [☐] Other: _________ | |
| **NEUROLOGIC:** | [☐] Headaches | [☐] Tingling | [☐] Decreased Mental Focus |
| | [☐] Numbness | [☐] Poor Balance | [☐] Foggy Thinking |
| | [☐] Weakness | [☐] Other: _________ | |
| **ENT:** | [☐] Hearing Loss | [☐] Ear Pain | [☐] Nasal Congestion |
| | [☐] Dizziness | [☐] Other: _________ | |
| **MUSCULOSKELETAL:** | [☐] Joint Pain | [☐] Decrease in Muscle Size | [☐] Swelling |
| | [☐] Decrease in Strength | [☐] Decrease in Performance | [☐] Muscle Pain |
| | [☐] Decrease in Endurance | [☐] Other: _________ | |
| **SKIN:** | [☐] Rashes | [☐] Suspicious Skin Lesions | |
| | [☐] Acne | [☐] Other: ___________ | |
| **PSYCHIATRIC:** | [☐] Anxiety | [☐] Insomnia | [☐] Irritability |
| | [☐] Depression | [☐] Other: ___________ | |
| **ENDOCRINE:** | [☐] Excessive Thirst | [☐] Other: ___________ | |
| | [☐] Hot/Cold Intolerance | | |

# 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:** ________