



www.DrWeightControl.com

## **Consent for Treatment by a Physician Assistant / Nurse Practitioner**

Physician's Weight Control and Wellness employs Nurse Practitioners (NPs) and Physicians Assistants (PAs). At our offices you may be seen by our doctor, or our NP or PA.

Nurse Practitioners and Physicians Assistants are not Physicians or Nurses, but skilled Health Care Practitioners who by formal experience in medical school are qualified to perform certain tasks under the supervision of a physician.

NPs and PAs are board certified and are required to participate in a designated number of hours of continuing medical education each year to maintain that certificate.

You may choose not to be seen by the NP or PA, please indicate below your preference.

This consent will remain in your permanent medical records. You may revoke this consent at any time.

I agree to see the Nurse Practitioner or Physician's Assistant \_\_\_\_\_

No, I do not want to be seen by the Nurse Practitioner or Physician's Assistant \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_



## New Patient No Show Policy

It is the policy of Physician's Weight Control & Wellness that should you fail to appear for your scheduled appointment at the designated time and/or fail to reschedule two (2) or more business days prior to your appointment, you will forfeit your \$50 deposit in full. You will then be required to pay another \$50 deposit in order to schedule another appointment. By providing us with your credit card information, or sending a money order or a cashier's check, or bringing in cash for this deposit you are acknowledging the receipt and understanding of this New Patient No Show Policy.

### No-Show Defined:

Failing to reschedule your appointment at least 48 hours before appointment time in one of the following ways will be considered a NO SHOW.

1. Talking directly to someone on our staff
2. Rescheduling by responding to your appointment email/text
3. Calling and leaving a clear message (first and last name, date of birth, date and time of appointment) on our answering machine. (After hour cancellation messages may be left 48 hours prior to your appointment. All messages are recorded and kept.)

#### ARLINGTON

716 Lincoln Sq.  
Arlington, TX 76011  
817-277-3469  
[Arlington@drweightcontrol.com](mailto:Arlington@drweightcontrol.com)

#### WACO

2122 Austin Ave.  
Waco, TX 76701  
254-754-1438  
[Waco@drweightcontrol.com](mailto:Waco@drweightcontrol.com)

In addition, arriving late to your scheduled appointment time will be considered a no-show and will result in rescheduling. If you are stuck in traffic, trying to get to our office, and find you will be a couple of minutes past your appointment time **PLEASE CALL OUR OFFICE IMMEDIATELY.**

We will try to work with you to avoid a no-show for the day resulting in a loss of your deposit.



# Hormone Restorative Therapy

## Arlington Office

716 Lincoln Square  
Arlington, TX 76011  
817-429-2929

## Waco Office

2122 Austin Ave.  
Waco, TX 76701  
254-754-1438

**Initial Visit:** Before your first appointment for Hormone Restorative Therapy our office **must have the following documentation on file**. When these documents are in our office you can then schedule your first appointment with our Doctor to discuss your Hormone Therapy. We cannot schedule your appointment without the required documentation – **no exceptions**.

### Required documentation for Women:

1. Current Mammogram report. This report must be dated less than ONE YEAR prior to your initial appointment.
2. Current Pap Smear report. This report must be dated less than THREE YEARS if last pap smear was within normal range and less than ONE YEAR if abnormal, prior to your initial appointment.  
*We do not perform or request mammograms, pap smears in our office.*  
*Please see your primary care physician to schedule these tests.*
3. After both 1 and 2 above are received in the office, women will need to complete hormone testing by blood sample or mailed Saliva kit.  
Bloodwork in our office is prior to the first appointment. Results are normally available in 1-2 business days. The cost for the initial blood work is \$340. You WILL need an appointment to have your blood drawn in our office. The cost of the saliva kit is \$195.00 and results will be sent to our office. The kit is done at home and must be mailed to the lab no less than 2 weeks before your appointment. You do not need an appointment to purchase your saliva kit.

### Required documentation for Men:

1. No documents prior to visit. We will do PSA, Testosterone and Metabolic Panel prior to first visit.
2. Your cost for all lab panels will be \$215.00 and testing will be done in the office prior to your first visit. You WILL need an appointment to have your blood drawn in our office.

**Office Visits:** You will be asked to return monthly so that adjustments may be made to the dosage of the hormones and/or supplements. Once your hormones have stabilized, you will be required to return to our office in six months for a re-check. On your six month visit it will be necessary to measure your hormone levels by repeating the saliva test/blood test so that you will be able to continue therapy.

**Prescriptions:** Hormone therapy prescriptions will be written to provide enough refills to last until your next scheduled office visit. If your follow up appointments are missed, we will be unable to issue any further refills until you see a Provider.



# Hormone Restorative Therapy

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2122 Austin Ave.  
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## **Existing Weight Control Patients Who Start Hormone Therapy: Initial consultation – Cost Waived**

**Women** – You must purchase and mail a saliva hormone test kit to the address listed on the box not less than 2 weeks prior to your first hormone appointment. If opting for bloodwork you must have an appointment with labs drawn 2 days or more before your first appointment. Results must be reviewed by our providers before they can see you for hormone treatment. The saliva kit can be purchased from our office for \$195 or blood work for \$250.

**Men** – You must have the testing outlined above for \$215 on the first visit.

**Follow-up Appointments** - Existing weight patients can combine their weight appointments with their hormone appointments for a charge of \$160. If you choose to have separate weight loss and hormone appointments the weight loss appointment will be the customary \$120 and your hormone appointment will be \$120.

**Six Months Lab Re-check for Hormone Levels** – Women will be required to do the saliva test again. You will purchase the kit from our office for \$195 and mail it in for your results. Men will repeat testing for \$215.

## **Patients who want Hormone Restorative Therapy only: Initial Consultation - \$120.**

*This charge includes consultation with our Providers. All testing and Rx is additional .*

**Women** – You must purchase and mail a saliva hormone test kit to the address listed on the box not less than 2 weeks prior to your first hormone appointment. If opting for bloodwork you must have an appointment with labs drawn 2 days or more before your first appointment. Results must be reviewed by our providers before they can see you for hormone treatment. The saliva kit can be purchased from our office for \$195 or blood work for \$250.

**Men** – You must have the testing outlined above for \$215 on the first visit.

**Follow-up appointments** for hormone therapy patients will be \$120.

**Six Months Lab Re-check for Hormone Levels** – You will be required to do the hormone testing again. Women will purchase the kit from our office for \$195 or bloodwork for \$250 and Men will have testing done in the office for \$215.

**ALL CHARGES ARE DUE AT TIME OF SERVICE and YOU MUST HAVE AN APPOINTMENT FOR ALL SERVICES  
(with the exception of picking up your saliva kit)**

***Your compounded hormones will be an additional cost to you and the cost can vary by the pharmacy you choose to have compound the prescription for you.***

**PAYMENT:** We do not accept checks in our office. We do accept credit cards, debit, or cash.

**We do not file insurance for any of our services.** If your insurance will cover the lab work it might be more affordable if you have your primary care physician request your lab for you. See below for the required testing. If you choose to have your blood drawn in our office a super bill will be provided for all services performed. This super bill may be submitted to your insurance company for reimbursement.

***Payment to our office is due, in full, the day of service.***



# Hormone Restorative Therapy

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If you would like to bring current lab work from another doctor the results **must** contain the following with **no exceptions**. All results must be dated less than six months prior to your initial appointment.

We will need these results two weeks before your hormone appointment so our doctor can review them.

## **Required Test Results for Women**

- \_\_\_ FSH
- \_\_\_ Testosterone
- \_\_\_ TSH
- \_\_\_ Estradiol
- \_\_\_ Testosterone
- \_\_\_ Free and Total with SHBG
- \_\_\_ uE3
- \_\_\_ LH
- \_\_\_ Progesterone
- \_\_\_ Free T3
- \_\_\_ Free T4
- \_\_\_ DHEA non-sulfate
- \_\_\_ Estrone (E1)
- \_\_\_ Estriol
- \_\_\_ Lipid Panel
- \_\_\_ CMP
- \_\_\_ CBC

## **Required Test Results for Men**

- \_\_\_ Testosterone
- \_\_\_ Estradiol
- \_\_\_ FSH
- \_\_\_ LH
- \_\_\_ Free T3
- \_\_\_ Free T4
- \_\_\_ SHBG
- \_\_\_ PSA
- \_\_\_ TSH
- \_\_\_ Lipid Panel
- \_\_\_ CMP
- \_\_\_ CBC

## Information Regarding Email Communication

To better serve our patients, each office has established an email address for some forms of communication. For routine matters that do not require immediate response, please feel free to contact us at [info@DrWeightControl.com](mailto:info@DrWeightControl.com). The turnaround time for routine patient communications using this email address is three to four business days. **Do not use this email to cancel or reschedule your appointment. Since this is not a routinely monitored email address a no show will result if you miss your appointment.** Do not use this email address to discuss your medications or ask medical questions.

When you are sending email to your office, please put the subject of your message in the subject line so we can process it more efficiently. Be sure to put your name, date of birth and return telephone number in the body of the message. Since this email address goes to one central location, tell us the office you are trying to contact (Arlington or Waco) in your email to us.

**Medication Refill Authorization forms are to be sent directly to your office.**

[Arlington@DrWeightControl.com](mailto:Arlington@DrWeightControl.com)

[Waco@drweightcontrol.com](mailto:Waco@drweightcontrol.com)

## Consent for Use of Email Communication

*This practice is dedicated to keeping your medical record information confidential. Communications relating to diagnosis and treatment will be filed in your medical record. We will not be emailing that information to you.*

### IT IS YOUR RESPONSIBILITY TO REMEMBER YOUR APPOINTMENT TIME

As a courtesy we try to email appointment reminders but on occasion we are not able to process the reminders.

**DO NOT depend on receiving appointment reminders to remember your next appointment.**

**If you miss your appointment, it will be considered a no-show regardless of whether or not you get a reminder.** Please initial that you have read and understand that it is your responsibility to remember your appointment time. \_\_\_\_\_

**Please do not use email in emergency situations. Should you require urgent or immediate attention, please call the office or go to the emergency room.**

**By signing below, you agree that you understand this policy and that we may send correspondence to you via email, and that we may respond to your emails to us via email.**

**Yes, I would like to have a copy of this Email Policy (please initial on the line)** \_\_\_\_\_

**No, I do not need a copy of this Email Policy (please initial on the line)** \_\_\_\_\_

\_\_\_\_\_  
Patient signature:

\_\_\_\_\_  
Date of Birth:

\_\_\_\_\_  
Your email address:

\_\_\_\_\_  
Today's Date:

**NOTICE:** Because email is not secure, please be aware of associated risks of email transmission. Because you have chosen to communicate patient identifiable information by email, you are consenting to associated email risks. We cannot guarantee that information transmitted will remain confidential.

Office Use Only:

This Email Policy was reviewed with patient by \_\_\_\_\_ (staff initial)

# Current Medication List

Please fill this form out completely.

The doctor will need to review all your medications each time you are in our office.

You may be asked to complete this form more than one time during the year.

It is very important that our doctors have an updated list of all your medications at all times.

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Today's Date \_\_\_\_\_

If there is ever a change in your medications let us know as soon as possible.

List **ALL** medications you are currently taking (prescriptions, over the counter, vitamins, minerals, etc.)

| Name of Medication | Strength | How many times a day do you take this medication? | How long have you been taking this medication? | Name of doctor who prescribed this medication. |
|--------------------|----------|---------------------------------------------------|------------------------------------------------|------------------------------------------------|
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## Do you have an allergy to any drugs?

Please list ALL prescriptions, over the counter, etc. drugs you are allergic to.

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# Bio-identical Hormone Replacement Program

## Disclosure / Liability Waiver

**READ CAREFULLY and COMPLETELY BEFORE SIGNING. If you have questions, please ask.**

While numerous safety measures are taken by our physicians and staff, incidental events may occur that are beyond the control of our physicians or staff. Within the medical community there are opposing views with respect to the use of Bio-identical hormonal replacement therapies. It has, however, been medically proven that the use of Bio-identical hormones provides true medical benefits. We are providing this treatment at our centers to lessen, or treat, non-life-threatening symptoms you have identified as bothersome and undesirable. **It is agreed that you are voluntarily participating in your treatment with Bio-identical hormonal replacement regimens and the use of any medications and/or supplements is undertaken at your own risk.** You are **voluntarily** assuming all risks of injury that might result. You hereby agree to waive any legal claims or rights you might otherwise peruse against Physician's Weight Control and Wellness Centers, their staff, or treating providers for injury during your voluntary participation in the Bio-identical Hormone Replacement Program.

***I have carefully read this waiver and fully understand that it is a release of liability to Physician's Weight Control and Wellness Centers due to any unforeseen complications of my voluntary participation in this program.***

I accept all terms and conditions of this program.

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Print Name

Date

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Signature

### **Maintenance of Preventative Medicine and Cancer Surveillance**

A requirement for acceptance and continuation in the Bio-identical Hormone Replacement Program is adherence to routine cancer screening. You **must** have current breast examinations, mammogram (if high risk or over age 40), and gynecological examinations (including PAP smears) before starting the program. We require that you have a copy of the results of these tests in our office **before** starting Bio-identical hormone replacement with our doctors and staff.

Your signature below indicates you will comply by obtaining the cancer screening examinations and tests with your primary care or gynecologic physician and have those results in our office **before** beginning the Bio-identical Hormone Replacement Program. ***You will not be allowed to start the program, or continue the program if your tests are not current (must have been done within the past year).***

I accept all terms and conditions of this program and will comply with all screening and testing.

---

Print Name

Date

---

Signature



## HIPAA Consent Form

I understand that as part of my health care, **Physician's Weight Control and Wellness** originates and maintains records describing my health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment,
- a means of communication among other health professionals who contribute to my care,
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

After reviewing the **HIPPA Notice of Privacy Practices** I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity. I consent to such disclosure for these permitted uses, including disclosures via fax. Any disclosures would be on an emergency or court ordered basis. Any other disclosures will require written consent from you.

I further understand that the **Physician's Weight Control and Wellness** has the right to change their **Notice of Privacy Practices** notice in accordance with the Code of Federal Regulations. Should the **Physician's Weight Control and Wellness** change the notice it will be posted on the website [www.DrWeightControl.com](http://www.DrWeightControl.com).

I have been provided and have the right to review the **Notice of Privacy Practices** that provides a complete description of how my personal information could be used or disclosed before signing this consent.

With whom may we discuss your treatment and medications provided by this office?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I fully understand and ☐ accept ☐ decline the terms of this consent.

I understand that after reviewing the **Notice of Privacy Practices** if I should choose to decline the terms of the notice I could be denied treatment at **Physician's Weight Control and Wellness Center**.

\_\_\_\_\_  
Patient's Signature (authorized representative signing for the patient)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Date

NOTE: This signed HIPAA Consent Form will remain in your file and considered current.

### FOR OFFICE USE ONLY

[ ] Consent received by \_\_\_\_\_ on \_\_\_\_\_

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on \_\_\_\_\_

**Confidentiality of Your Health Care Information**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.**

*We are required by law to provide you with this notice of our legal duties and privacy practices concerning your private health information.* By law we must follow the terms of the Notice of Privacy Practices that we have in effect.

If you have questions about this notice, please contact the Privacy Officer at (817) 277-3469. This notice describes Physician's Weight Control and Wellness privacy practices and that of:

- All employees.
- Any intern, volunteer or IT personnel that we allow to input or maintain patient data files.
- All internal departments of Physician's Weight Control and Wellness Center
- All locations owned by Physician's Weight Control and Wellness.

**Our Commitment to Your Privacy**

We have always had stringent safeguards to protect private health information (PHI), however, because of a new law some changes are necessary to assure you we are dedicated to maintaining the privacy of your health information. In conducting our business, we may receive, create, use, or disclose protected health information regarding you and the treatments and services we provide you. *None of your protected health information will leave our office without your written consent.*

**Health Information Security -**

Physician's Weight Control and Wellness requires all employees to follow security policies and procedures to safeguard your PHI.

**Understanding your Medical Record**

**Information** - The information we have on you is called your private health information (PHI). We create a record of the care and services you receive in our office. This record will contain your prescription information, doctor's progress notes, medical history or other documentation the doctor chooses to include in your medical record.

**To summarize, this notice provides you with the following important information:**

- How we use and disclose your PHI.
- Your privacy rights of your PHI.
- Our obligations concerning the use and disclosure of your PHI.

**How We May Use and Disclose Medical Information About You**

**For Treatment** - We will use health information about you to provide medical treatment or services. Our doctors, medical assistants and office personnel will all have access to your health information.

**For Health Care Operations** - We may use your protected health information in order to perform our daily business activities, which may include data management, customer service, complying with laws and quality. Your health information may be used to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer or how we can become more efficient. **To Avert a Serious Threat to Health or Safety** - We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to someone able to help stop or reduce the threat.

**Research** - We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office. **Military** - If you are, or were, a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release

information about foreign military personnel to the appropriate foreign military authority. **Public Health Risks** - We may disclose health information about you for public health activities. These activities generally include, but are not limited to the following:

- To prevent or control disease, injury or disability.
- To regulate products subject to FDA regulations.
- To notify the appropriate government agency if we think a patient has been the victim of abuse, neglect, or domestic violence **Health Oversight Activities** - We may disclose health information to a health oversight agency for audits, investigations, inspections, accrediting or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws. Generally, these audits are done in our office and will not require a signed consent from you.

**As Required by Law** - We will disclose health information about you when required to do so by federal, state, or local law enforcement.

**Judicial Proceedings** - If you are involved in a lawsuit or a dispute and we are asked to disclose health information about you in response to a court order or subpoena we will legally have to comply to those orders.

**Law Enforcement** - We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

**Coroners, Medical Examiners and Funeral Directors** - We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death or as necessary to carry out

their duties. If you have listed someone you do not want your records revealed to, that person would not be allowed to get a copy of your PHI even in the event of your death.

#### ***Information Not Personally***

***Identifiable*** - We may use or disclose health information about you in a way that does not personally identify you or reveal who you are. This is usually generic information to help improve or create new medications.

#### ***Individuals Involved in the Treatment or Payment of Your Care***

- We may disclose health information about you to your family members or friends *if* we obtain written consent by you to do so.

**Business Associates** – There are some services that we provide through contracts with third party business associates. Examples include external laboratories and information technology associates. To protect your health information, PWCWC requires business associates to sign a disclosure agreement before they can have access to any information pertaining to the company or patients.

**Consent Forms** You may revoke any consent form at any time by giving us written notice. Your revocation will be effective when we receive your written notice. Any disclosures prior to receiving your written revocation of that particular consent form will not be subject to your revocation.

#### **Your Rights Regarding Health**

**Information About You** - You have the following rights regarding health information we maintain about you.

**Right to Inspect and Copy** - You have the right to inspect and request a copy of certain health information we have on file. Usually, this includes medical and billing records. To inspect and request a copy of health information on file about you, you must submit a written request. If you request a copy of your health information, we may charge a fee for the costs of copying, mailing, or other associated supplies. We may deny your request to inspect or receive a copy in certain limited cases. If we deny your request, you may ask for a review of the denial. The person who conducts the review will not be the person who denied the request. We will comply with the outcome of the review. **Right to**

**Request an Amendment** - If you believe the medical information, we have about you is incorrect or incomplete; you may ask us to amend the information. You have the right to request an amendment as long as the information originated at PWCWC. You must request an amendment in writing and submit it to the Privacy Officer. You must also tell us the reason for your request. The request to amend your record may be denied, in which case you have the right to enter a statement into your record saying that you disagree with the decision.

#### **Right to an Accounting of Disclosures**

You have the right to request an “accounting of disclosures.” This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to the Privacy Officer. It must state a time period, which may not be longer than six years. We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**Right to Request Restrictions** - You have the right to request a restriction or limitation on the health information we disclose about you for treatment, payment or health care. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. We are not required to agree to your request, but, if we do agree, we will comply with your request unless the information is needed to provide emergency treatment for you. You must submit your request for restrictions in writing to the Privacy Officer. In your request, you must tell us: - The information you want restricted. - To whom you want the restrictions to apply, such as your spouse or another relative. The Privacy Officer will inform you if disclosure is made to someone on your restricted list; this disclosure will only be made in case of a health emergency.

#### **Right to Request Confidential**

**Communications** - You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For

example, you can ask that we only contact you at work or by mail. You must submit your request for confidential communication in writing. Your request must specify how or where we should contact you. We will try to accommodate all reasonable requests.

#### **Other Uses of Medical Information**

- Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will only be made with your written permission. If you provide us with permission to use or share your medical information, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or share your health information for the reasons in your written revocation. Any information disclosed before your written revocation will not be subject to this revocation.

#### **Changes to this Notice**

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have, as well as information we receive in the future. We will post copies of the current notice on our website, [www.drweightcontrol.com](http://www.drweightcontrol.com). The notice will contain the effective date of the notice in the top right-hand corner of the first page.

#### **Right to a Paper Copy of This Notice**

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. This notice is also available on our website, [www.drweightcontrol.com](http://www.drweightcontrol.com).

#### **For More Information or to Report a Problem**

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be in writing. There will be no retaliation for filing a complaint.

#### **To file a complaint with our office you may contact our privacy officer:**

Privacy Officer Physician's Weight Control and Wellness  
716 Lincoln Square  
Arlington, TX 76011

*If there is ever a breach of your personal health information by our office you will be notified immediately.*

I understand that as part of my health care, **Physician's Weight Control and Wellness** originates and maintains records describing my health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment,
- a means of communication among other health professionals who contribute to my care,
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

After reviewing the **HIPPA Notice of Privacy Practices** I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity. I consent to such disclosure for these permitted uses, including disclosures via fax. Any disclosures would be on an emergency or court ordered basis. Any other disclosures will require written consent from you.

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I further understand that the **Physician's Weight Control and Wellness** has the right to change their **Notice of Privacy Practices** notice in accordance with the Code of Federal Regulations. Should the **Physician's Weight Control and Wellness** change the notice it will be posted on the website [www.DrWeightControl.com](http://www.DrWeightControl.com).

I have been provided and have the right to review the **Notice of Privacy Practices** that provides a complete description of how my personal information could be used or disclosed before signing this consent

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Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home or Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Work activity level: ☐ sedentary ☐ mildly active ☐ very active physically demanding  
 What are the ages of your children: \_\_\_\_\_ How did you hear about us: \_\_\_\_\_

Briefly Describe Your Present Symptoms: \_\_\_\_\_

What do you feel is the most important factor to your present symptoms? \_\_\_\_\_

**Medical History** – List all medical problems or illnesses you have or have had; include hospitalizations for illnesses or accidents.

| Date | Describe the Medical Diagnosis – was this an Illness or an Accident |
|------|---------------------------------------------------------------------|
|      |                                                                     |
|      |                                                                     |
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**Surgical History**

| Date | Surgery |
|------|---------|
|      |         |
|      |         |
|      |         |

**Medications** – List ALL prescription medications and ALL over the counter medications including vitamins

| Name of Medication | Dosage | Schedule |
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**Allergies to Medications** – List ALL MEDICATIONS (prescriptions or over the counter) you are allergic to

| Medication | What happens when you take it |
|------------|-------------------------------|
|            |                               |
|            |                               |
|            |                               |
|            |                               |
|            |                               |

**Family History** – List ALL illnesses (heart disease, stroke, diabetes, hypertension, cancer of any type), etc.

| Relationship | Age when occurred | Medical Problem (If Death occurred list Problem and age at time of Death) |
|--------------|-------------------|---------------------------------------------------------------------------|
| Mother       |                   |                                                                           |
| Father       |                   |                                                                           |
| Brothers     |                   |                                                                           |
| Sisters      |                   |                                                                           |
| Children     |                   |                                                                           |
| Spouse       |                   |                                                                           |

# Bio-Identical Hormone Replacement Questionnaire for Men

**Social History** – This information is strictly confidential and will be used only to address symptoms and/or complaints

|                                                                                                                                                                                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Do you smoke cigarettes now or have you in the past? Yes____ No____<br>If yes, how many packs per day? _____ How many years have you, or did you smoke? _____                    |
| Do you drink alcohol? Yes____ No____<br>If yes, how many drinks do you usually have in a week? _____<br>What do you usually drink (beer, wine, bourbon, etc.)? _____             |
| Do you now, or have you ever used illicit drugs (marijuana, amphetamines, narcotics, psychedelics, cocaine, etc.)? Yes____ No____<br>If yes, what substance and how often? _____ |

## Check-up History

|                              |                                       |
|------------------------------|---------------------------------------|
| Date of last PSA: _____      | Date of last complete check-up? _____ |
| Physician: _____             | Facility? _____                       |
| Physician's Phone # _____    | Facility's Phone # _____              |
| Primary Care Physician _____ |                                       |

|                                                                                            |         |        |
|--------------------------------------------------------------------------------------------|---------|--------|
| Have you ever had an abnormal PSA? If yes, what was the abnormality and follow up you had? | Yes____ | No____ |
| Have you ever had an abnormal test If yes, what was the abnormality and follow up you had? | Yes____ | No____ |
| Have you ever had any kind of prostate problems?                                           | Yes____ | No____ |

Do you have a history of any type of **cancers**:

Date: \_\_\_\_\_ Type: \_\_\_\_\_  
 Date: \_\_\_\_\_ Type: \_\_\_\_\_

Do you exercise regularly? Yes\_\_\_\_ No\_\_\_\_ If yes, what type of exercise do you do? \_\_\_\_\_

How would you rate the current level of stress in your life at this time?

(Please circle) No Stress—1—2—3—4—5—6—7—8—9- Very Stressed

Do you sleep well? Yes\_\_\_\_ No\_\_\_\_ Describe your typical sleep pattern \_\_\_\_\_

Do you currently have major life stressors? \_\_\_\_marriage \_\_\_\_children \_\_\_\_finances \_\_\_\_job  
 Other \_\_\_\_\_

Do you eat a healthy diet? Yes\_\_\_\_ No\_\_\_\_ Explain if no \_\_\_\_\_

**Hormone Therapy History:** If you have ever been treated with hormone replacement, either prescription or over the counter, please list and give the reason for treatment.

| Hormone | Dose | Reason | Start Date | Stop Date |
|---------|------|--------|------------|-----------|
|         |      |        |            |           |
|         |      |        |            |           |
|         |      |        |            |           |
|         |      |        |            |           |

# Bio-Identical Hormone Replacement Questionnaire for Men

**Androgens:** (check if troublesome and/or persistent)

## Androgen Excess Androgen Deficiency

|                     |  |
|---------------------|--|
| Increased Body Hair |  |
| Acne                |  |
| Oily Skin           |  |
| Nervous             |  |
| Irritable/Irritable |  |
| Anxious             |  |
| Depressed           |  |
| Sleep Disturbances  |  |
|                     |  |
|                     |  |
|                     |  |

## Androgen Deficiency

|                       |  |
|-----------------------|--|
| Low Libido            |  |
| Fatigue               |  |
| Aches/Pains           |  |
| Memory Lapses         |  |
| Foggy Thinking        |  |
| Depressed             |  |
| Anxious/Irritable     |  |
| Sleep Disturbances    |  |
| Thinning Skin         |  |
| Decreased Muscle Mass |  |
| Headaches             |  |

**Adrenals:** (check if troublesome and/or persistent)

## Cortisol Excess

|                           |  |                       |  |
|---------------------------|--|-----------------------|--|
| Sleep Disturbances        |  | Acne                  |  |
| Sugar Cravings            |  | Memory Loss           |  |
| Fatigue                   |  | Increased Body Hair   |  |
| Weight Gain – mid section |  | Headaches             |  |
| Loss of Muscle Mass       |  | Stress                |  |
| Thinning Skin             |  | Cold Body Temperature |  |
| Elevated Triglycerides    |  | Hair Loss             |  |
| Low Libido                |  |                       |  |
| Irritable/Anxious/Nervous |  |                       |  |

## Cortisol Deficiency

|                       |  |
|-----------------------|--|
| Fatigue               |  |
| Sugar Craving         |  |
| Allergies             |  |
| Chemical Sensitivity  |  |
| Stress                |  |
| Cold Body Temperature |  |
| Irritable             |  |
| Arthritis             |  |
| Aches/Pains           |  |

**Thyroid:** (check if troublesome and/or persistent)

## Thyroid Excess

|                                   |  |
|-----------------------------------|--|
| Heat Intolerance                  |  |
| Insomnia                          |  |
| Palpitations                      |  |
| Weight Loss                       |  |
| Tremors/Shakiness                 |  |
| Diarrhea                          |  |
| Nervousness/Anxious/Panic Attacks |  |
| Muscle Weakness                   |  |
| Coarse Dry Skin                   |  |

## Thyroid Deficiency

|                          |  |
|--------------------------|--|
| Cold Intolerance         |  |
| Constipation             |  |
| Fatigue/Weakness         |  |
| Unexplained Weight Gain  |  |
| Inability to Lose Weight |  |
| Lack of Motivation       |  |

# Bio-Identical Hormone Replacement Questionnaire for Men

**System Review** – Check the appropriate box for each question.

| <b>Constitutional / ID / Oncology</b>                         | <b>Yes</b> | <b>No</b> |
|---------------------------------------------------------------|------------|-----------|
| Have you had unexplained weight loss?                         |            |           |
| Do you have fever or chills?                                  |            |           |
| Do have night sweats?                                         |            |           |
| Do you notice swollen lymph nodes?                            |            |           |
| Have you ever been diagnosed with cancer?                     |            |           |
| Have you ever tested positive of HIV?                         |            |           |
| Have you ever had a sexually transmitted disease?             |            |           |
| <b>Respiratory</b>                                            | <b>Yes</b> | <b>No</b> |
| Do you have a cough?                                          |            |           |
| Do you frequently sneeze?                                     |            |           |
| Do you have excessive daytime sleepiness?                     |            |           |
| Do you snore?                                                 |            |           |
| Have you ever been diagnosed with asthma or emphysema         |            |           |
| <b>Cardiovascular</b>                                         | <b>Yes</b> | <b>No</b> |
| Do you have chest pain?                                       |            |           |
| Do you have palpitations?                                     |            |           |
| Do you have shortness of breath?                              |            |           |
| Do you have swelling in your legs?                            |            |           |
| Do you have leg pain while walking?                           |            |           |
| Have you been diagnosed with any heart condition?             |            |           |
| Have you ever been diagnosed with a blood clot?               |            |           |
| <b>Gastrointestinal</b>                                       | <b>Yes</b> | <b>No</b> |
| Do you have trouble swallowing food? (reflux)                 |            |           |
| Do you have nausea or vomiting?                               |            |           |
| Do you have diarrhea?                                         |            |           |
| Do you have blood in your stool?                              |            |           |
| Do you have abdominal pain or swelling?                       |            |           |
| Have you ever been diagnosed with hepatitis or liver disease? |            |           |
| <b>Endocrine</b>                                              | <b>Yes</b> | <b>No</b> |
| Do you urinate frequently or in larger amounts than usual?    |            |           |
| Do you have a greater than normal urge to eat?                |            |           |
| Are you excessively thirsty?                                  |            |           |
| Do you have acne?                                             |            |           |
| Have you ever been diagnosed with a thyroid problem?          |            |           |
| <b>Neurological</b>                                           | <b>Yes</b> | <b>No</b> |
| Do you have muscle weakness?                                  |            |           |
| Have you ever had a seizure?                                  |            |           |
| Have you experience double vision or blind spots?             |            |           |
| Have you ever been diagnosed with a stroke?                   |            |           |
| Do you have burning when you urinate?                         |            |           |
| Do you have urgency when you urinate?                         |            |           |
| Do you urinate more frequently than others?                   |            |           |
| Do you leak urine when laughing or coughing?                  |            |           |
| Have you ever had any kidney problems?                        |            |           |

# Bio-Identical Hormone Replacement Questionnaire for Men

**MEDICAL HISTORY QUESTIONNAIRE:** Patient will submit a truthful, accurate, and complete Medical History Questionnaire. Patient also acknowledges that failure to provide accurate, truthful, and complete information on this Questionnaire to the Physician(s) of Physician's Weight Control and Wellness Centers could result in inappropriate treatment. \_\_\_\_\_

Initial

(All information contained in this questionnaire is strictly confidential, will be protected to the highest of HIPAA standards, and will become part of your PWCWC medical record.)

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Notes:

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## Patient Privacy Questionnaire (HIPAA)

### Physician's Weight Control and Wellness Centers

**Name of Patient** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

Names and contact numbers of persons, if any, we may contact in an emergency.

(name) \_\_\_\_\_ (phone #) \_\_\_\_\_

(name) \_\_\_\_\_ (phone #) \_\_\_\_\_

Name of person who has permission to cancel or reschedule appointments for you.

(name) \_\_\_\_\_ (relationship) \_\_\_\_\_ (date of birth) \_\_\_\_\_

If you would like correspondence from our office sent to an address other than your home please specify.

Are there any special instructions how correspondence may be sent to you? \_\_\_\_\_

Please provide an e-mail address we could send correspondence to. \_\_\_\_\_

**\*\* May we email an appointment reminder to you?** Yes \_\_\_\_\_ No \_\_\_\_\_

List the telephone numbers where we may call you. If you do not want to be called at a certain number do not list that number. Cell phones, voicemail, and answering machines are not completely private.

Home Phone \_\_\_\_\_

May we leave a message on the answering machine? Yes \_\_\_\_\_ No \_\_\_\_\_

If someone answers your home phone may we leave a message with that person? Yes \_\_\_\_\_ No \_\_\_\_\_

Cell Phone \_\_\_\_\_

May we leave a message on voice mail? Yes \_\_\_\_\_ No \_\_\_\_\_

Work Phone \_\_\_\_\_

May we leave a message on voice mail? Yes \_\_\_\_\_ No \_\_\_\_\_

PATIENT'S NAME (please print) \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**NOTE:** This signed Privacy Questionnaire will remain in your file and considered current. If there are any changes you must notify our office and complete another form.



## Hormone Concurrent Treatment Disclosure

At Physician's Weight Control and Wellness our patient's health and safety is vitally important to us. With this in mind, it is necessary that each patient fully inform the office staff and/or physician when there is any change in treatment, medication, or care being provided by another medical facility. This disclosure includes any new health issues, or changes in ongoing treatment for any medical condition you may have. In addition, it is vital that no one under the care of Physician's Weight Control and Wellness be under the care of another facility or clinic for Hormone Restorative Therapy without full disclosure of such to the staff of this office.

The decision will be up to the physicians of our clinic to determine if our treatment is medically compatible with any other form of treatment you may be receiving. Furthermore, failure of full disclosure of concurrent Hormone Restorative Therapy treatments could be grounds for dismissal from our clinic. Please know that it is for your health and well-being that we must have a complete and full disclosure of medical or Hormone Restorative Therapy treatments you are undergoing outside of this facility.

I have read the above statement and agree to follow the standards as outlined.

Patient's Signature \_\_\_\_\_ Date of Birth \_\_\_\_\_

Date Signed \_\_\_\_\_

**NOTICE:** *If you have chosen to communicate patient identifiable information by email, you are consenting to associated email risks. We cannot guarantee that information transmitted will remain confidential because not all emails are secure, please be aware of associated risks of email transmission.*