Bio-Functional Med: Male New Patient Package

Name: _____ Today's Date: _____
(Last) (First) (Middle)

DateofBirth:_____Age:_____Weight:_____Occupation:_____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

E-Mail Address: _____ May we contact you via E-Mail? ( ) **YES** ( ) **NO**

In Case of Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Primary Care Physician's Name: _____ Phone: _____

Address: _____
Address City State Zip

Marital Status (check one): ( ) Married ( ) Divorced ( ) Widow ( ) Living with Partner ( ) Single

In the event we cannot contact you by the mean's you've 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.

Spouse's Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Social:

( ) I am sexually active.
( ) I want to be sexually active.
( ) I have completed my family.
( ) I have used steroids in the past for athletic purposes.

Habits:

( ) I smoke cigarettes or cigars _____ a day.
( ) I drink alcoholic beverages _____ per week.
( ) I drink more than 10 alcoholic beverages a week.
( ) I use caffeine _____ a day.

BIO FUNCTIONAL MED

Bio-Functional Med: Medical History

Any known drug allergies: _____

Have you ever had any issues with anesthesia? ( ) Yes ( ) No
If yes please explain: _____

Medications Currently Taking: _____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Nutritional/Vitamin Supplements: _____

Surgeries, list all and when: _____

Other Pertinent Information: _____

ED Meds: _____

Medical Illnesses:

( ) High blood pressure.
( ) High cholesterol.
( ) Heart Disease.
( ) Stroke and/or heart attack.
( ) Blood clot and/or a pulmonary emboli.
( ) Hemochromatosis.
( ) Depression/anxiety.
( ) Psychiatric Disorder.
( ) Cancer (type): _____
Year: _____

( ) Testicular or prostate cancer.
( ) Elevated PSA.
( ) Prostate enlargement.
( ) Trouble passing urine or take Flomax or Avodart.
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis).
( ) Diabetes.
( ) Thyroid disease.
( ) Arthritis.
( ) Other_____

_____ _____ _____
Print Name **Signature** **Today's Date**

BIO FUNCTIONAL MED

Bio-Functional Med: BHRT CHECKLIST FOR MEN

Name: _____ **Date:** _____

Symptom *(please check mark)*	Never	Mild	Moderate	Severe
Decline in general well being				
Joint pain/muscle ache				
Excessive sweating				
Sleep problems				
Increased need for sleep				
Irritability				
Nervousness				
Anxiety				
Depressed mood				
Exhaustion/lacking vitality				
Declining Mental Ability/Focus/Concentration				
Feeling you have passed your peak				
Feeling burned out/hit rock bottom				
Decreased muscle strength				
Weight Gain/Belly Fat/Inability to Lose Weight				
Breast Development				
Shrinking Testicles				
Rapid Hair Loss				
Decrease in beard growth				
New Migraine Headaches				
Decreased desire/libido				
Decreased morning erections				
Decreased ability to perform sexually				
Infrequent or Absent Ejaculations				
Results from E.D. Medications				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		

BIO FUNCTIONAL MED

BFM FINANCIAL POLICY CONSENT FORM

Private Pay Practice Bio-Functional MED is set up as a self-pay private practice, we are not in network with any insurance companies. Bio-Identical hormone therapy and wellness treatments are not considered essential services by insurance companies and, as such, are not covered. Additionally, our cash based self-pay model of practice allows us to spend more time with our clients and this is both satisfying for our clients and providers. We are able to pass cost savings on labs and treatments to our clients. Our pricing is transparent and clear. We will never pressure you to get treated.

Not Covered by Insurance. Bioidentical Hormone Replacement Therapy (BHRT) is an elective wellness therapy. In keeping with a free enterprise philosophy, our policy regarding insurance has always been that we choose to work directly with our patients rather than through an insurance company. Our clients must agree not to seek reimbursement from medical care received at our office. We are not able to furnish information or answer questions for insurance companies. We are not able to provide ICD10 Diagnosis codes or CPT Codes to generate billing sheets for insurance companies. We are not treating disease. Our doctors do not generate notes that can be used for billing purposes. In keeping with our philosophy, patients are afforded the luxury of treatment without the interference of insurance companies. Our focus is the premier care we provide.

Labs. Insurance companies do not always cover wellness or functional medicine labs. Your labs may not be covered if you go to an outside facility and you will be responsible. In some instances, the wellness codes that we use will not be covered by your insurance company for labs. We offer labs for a cash price. We cannot order laboratory testing prior to the consultation.

Services and Goods. By signing this financial policy. I have been advised that most insurance companies do not consider Bio-identical hormone therapy and wellness treatment to be a covered benefit. I acknowledge that my provider has no contracts with any insurance company and is not contractually obligated to pre- certify treatment with my insurance company or answer letters of appeal. If products or treatments are ordered, they are specific to you and they cannot be refunded. In some instances, supplements and goods will incur a 20% restocking fee if returned.

Consultation. Hormone optimization is a complex process. You will be asked to complete a detailed medical history and symptom checklist. Your initial provider meeting may require a long consultation to review your medical and surgical history, your medications, your symptoms and determine which labs are needed. The provider will also discuss risks and benefits of treatment. There are different treatment routes to review and ensure that your treatment goals can be met. The consultation fee is required up front and must be paid in full. The consultation fee is non-refundable. Our providers have more than 20+ years cumulative experience evaluating and maximizing hormone optimization. Our providers have undergone extensive training in hormone management and our providers are required to complete additional continuing education coursework on the latest treatments. The provider will then make recommendations and discuss further testing requirements if needed.

_____

Print Name Signature Date

BIO FUNCTIONAL MED

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 healthcare 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 the 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, _____ date _____ 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.

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

Patient Information Full Name: _____
Social Security Number: _____ Date of Birth: _____
Address: _____
_____
Phone Number: _____ Email Address: _____

1. The following specific person(s) or class of persons or facility is authorized to make the requested use or disclosure:
_____
_____

2. I, _____, hereby authorize the use or disclosure of protected health information concerning myself to the following person(s) or class of persons:
_____
_____

3. I also request that the Medical Records be released to the following:
Organization/Individual's Name: _____
Address: _____
_____
Phone Number: _____ Fax Number: _____
Organization/Individual's Name: _____
Address: _____
_____
Phone Number: _____ Fax Number: _____

4. The specific information that should be disclosed is all medical records, treatments, x-rays, diagnostic laboratory test results, progress notes, and any other similar medical records on me.
Other:_____
_____

5. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

6. I may hereby revoke this authorization by notifying _____ in writing of my desire to revoke it. However, I do understand that any action already taken in reliance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that my refusal to sign will not affect my ability to obtain treatment from or the payment to the medical provider to whom this authorization is furnished.

7. The purpose of the requested use or disclosure is at the request of the individual patient.

8. I ask that the Medical Records be released within the next thirty (30) days as required by the Health Insurance Portability and Accountability Act ("HIPAA")

9. This release will be valid until _____, or until written notice is sent by me therefore revoking the release before the aforementioned end date. _____

Signature of Patient/Claimant -orAuthorized Representative of the above-referenced Patient:

Full Name: _____Sig: _____ Date_____

_____ Signature of Authorized Representative Date_____