PATIENT INFORMATION FORM

Last Name: _____ First Name: _____ M.I. _____ Sex: M F
Social Security #: _____ Date of Birth: _____ Age: _____
Address: _____ City: _____ State: _____ Zip: _____
Home#: _____ Cell#: _____ Work#: _____
Name of Employer: _____ Email: _____

How did you hear about us? Radio Cinema Search Engine Friend/Family

INSURANCE INFORMATION

Primary Insurance: _____ Policy Holder: _____
ID#: _____ Group#: _____ Phone#: _____
Insurance Address: _____ City: _____ State: _____ Zip: _____

In case of EMERGENCY, notify: _____ Phone#: _____
Relationship: _____

PLEASE CIRCLE ONE

Minor Single Married Divorced Widowed

HIPAA INFO: Instructions for the office when returning phone calls or reminding you about appointments.

You may leave messages at: Home Work Cell

Patient (or Parent/Guardian) Signature: _____ Date: _____

Low Testosterone Men's Clinic

Medical/Surgical History:_____

Current Medications:_____

Allergies:_____

Past History

YES NO Have you ever had an abnormal PSA(prostate) test?

YES NO Have you ever had prostate or breast cancer?

YES NO Have you ever had any surgery in the prostate or the genital area(Vasectomy/hernia repair)?

YES NO Have you been told that you have erythrocytosis (thickening of blood)?

YES NO Are you being treated for benign prostatic hypertrophy?

YES NO Do you have liver disease/damage?

Family History:_____

YES NO Do you have any blood related family with prostate cancer? If yes, who_____

YES NO Do you have any blood related family with other cancers? If yes, which_____

Social History: _____

YES NO Do you smoke? If Yes, how much?_____

YES NO Do you drink alcoholic beverages? If Yes, how much?_____

General- □ Fatigue □ Sleeping more than usual □ Weakness □ Cry easily/often □ Aches/Pains

Genital Male- □ Low libido(desire) □ Poor erection □ Cannot sustain an erection □ Deformity of erection □ Decreased testicular size □ Pain □ Penile discharge □ Premature ejaculation □ Less waking erections

Psychiatric- □ Depression □ Moodiness □ Anxiety □ Sleep problems □ Trouble falling asleep □ Trouble staying asleep □ Loss of appetite □ Suicidal thoughts

Endocrine- □ Weight gain/loss □ Excessive sweating □ Excessive thirst □ Excessive urination □ Heat or cold intolerance □ Loss of hair to underarms and genitals □ Hot flashes

Eyes- □ Vision change □ Loss of partial vision □ Flashing lights □ Spots in visual

Cardiovascular- □ Chest pain or discomfort □ Palpitations □ Swelling

Breast- □ Breast enlargement □ Breast tenderness □ Masses/Lumps

Neurologic- □ Headaches □ Decreased memory □ Decreased concentration □ Seizures

Osteoporosis evaluation- □ Broken bones without injury □ Decrease in height

Do you want to have any more children? YES NO

Do you currently have a primary care physician? YES NO

Sexual Health Inventory for Men

Patient Instructions

Sexual health is an important part of an individual's overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help you and your doctor identify if you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with your provider.

Each question has several possible responses. Circle the number of the response that best describes your own situation. Please be sure that you select one and only one response for each question.

Over the past six months:

1. How do you rate your confidence that you could get and keep an erection?		Very Low 1	Low 2	Moderate 3	High 4	Very High 5
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?	No Sexual Activity 0	Almost Never or Never 1	A Few Times (much less than half the time) 2	Sometimes (about half the time) 3	Most Times (much more than half the time) 4	Almost Always or Always 5
3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	Did Not Attempt Intercourse 0	Almost Never or Never 1	A Few Times (much less than half the time) 2	Sometimes (about half the time) 3	Most Times (much more than half the time) 4	Almost Always or Always 5
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	Did Not Attempt Intercourse 0	Extremely Difficult 1	Very Difficult 2	Difficult 3	Slightly Difficult 4	Not Difficult 5
5. When you attempted sexual intercourse, how often was it satisfactory for you?	Did Not Attempt Intercourse 0	Almost Never or Never 1	A Few Times (much less than half the time) 2	Sometimes (about half the time) 3	Most Times (much more than half the time) 4	Almost Always or Always 5

Add the numbers corresponding to questions 1-5. Total: _____

The Sexual Health Inventory for Men further classifies ED severity with the following breakpoints:

1-7 Severe ED 8-11 Moderate ED 12-16 Mild to Moderate ED 17-21 Mild ED

AUA SYMPTOM SCORE (AUASS)

PATIENT NAME: _____ **TODAY'S DATE:** _____

(Circle One Number on Each Line)	Not at All	Less Than 1 Time in 5	Less Than Half the Time	About Half the Time	More Than Half the Time	Almost Always
Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
During the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
During the past month or so, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
During the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
During the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
During the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
	None	1 Time	2 Times	3 Times	4 Times	5 or More Times
Over the past month, how many times per night did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5

Add the score for each number above and write the total in the space to the right. **TOTAL:** _____

SYMPTOM SCORE: 1-7 (Mild) 8-19 (Moderate) 20-35 (Severe)

QUALITY OF LIFE (QOL)

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	0	1	2	3	4	5	6

LOW TESTOSTERONE MEN'S CLINIC
NOTICE OF PRIVACY PRACTICES

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

Protecting your privacy

Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper or the Internet. At our practice. (**hereinafter referred to as "the Practice")**, privacy is one of our highest priorities.

Keeping your information

Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and will handle your information with care. Our employees access information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims and otherwise meet your needs. We may also access information about you when considering a request from you or when exercising our rights under the law or any agreement with you.

We safeguard information during all business practices according to established security standards and procedures, and we continually assess new technology for protecting information. Our employees are trained to understand and comply with these information principles.

Working to meet your needs through information

In the course of doing business, we collect and use various types of information, like name and address and claims information. We use this information to provide service to you, to process your claims and to bring you health information that might be of interest to you.

Keeping information accurate

Keeping your health information accurate and up-to-date is very important. If you believe the health information we have about you is incomplete, inaccurate or not current, please call or write us at the telephone numbers or addresses listed below. We take appropriate action to correct any erroneous information as quickly as possible through a standard set of practices and procedures.

How – and why – information is shared

We limit who receives information and what type of information is shared.

· *Sharing information within **the Practice.*** We share information within our company to deliver you the health care services and the related information and education programs specified in your plan.

· *Sharing information with companies that work for us.* To help us offer you our services, we may share information with companies that work for us, such as claim processing and mailing companies and companies that delver health education and information directly to you. These companies act on our behalf and are obligated contractually to keep the information that we provide them confidential.

· *Other.* Patient-specific personally identifiable data is released only when required to provide a service for you and only to those with a need to know, or with your consent. Data is released with the condition that the person receiving the data will not release it further, unless you give permission.

If we received a subpoena or similar legal process demanding release of any information about you, we will attempt to notify you (unless we are prohibited from doing so). Except as required by law or as described above, we do not share information with other parties, including government agencies.

The Practice does not share any customer information with third-party marketers who offer their products and services to our patients.

Count on our commitment to your privacy

You can count on us to keep you informed about how we protect your privacy and limit the sharing of information you provide to us – whether it's at our office, over the phone or through the Internet.

Low Testosterone Men's Clinic
5604 Colleyville Blvd, Ste. H
Colleyville, TX 76034

Low Testosterone Men's Clinic
6115 Camp Bowie Blvd, Ste. 140
Fort Worth, TX 76116

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as a part of the provision of healthcare services, Low Testosterone Men's clinic, L.P. creates and maintains health records and other information describing, among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have a right to review the notice before signing this consent. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested. By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment, and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. **Any and all records, whether written or oral in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.**
2. **A photocopy or fax of this consent is as valid as this original.**
3. **I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations, be restricted. I also understand that the Practice and I must agree to any restriction in writing that I requested on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.**
4. **This authorization is valid until the termination of current health insurance.**

_____ Date_____

Patient's name printed

_____

Patient's signature

<u>Your Insurance coverage</u> is an agreement between you and your insurance company. We agree to file the claim for you and accept the contracted payment.

It is your responsibility to remit payment for deductibles, co-pays and charges not covered by the plan. In order for this office to process your claim, it is important that you present your insurance card at each visit. The card must match the patient being seen.

If a problem occurs with your claim, coverage is terminated or denied, it is your responsibility to contact your insurance and insure payment or initiate a payment plan with our practice until your insurance problem is resolved. Past due accounts are subject to credit processing.

<u>Consent to treatment:</u> I hereby grant permission to the physician in charge of my case and such assistants as he or they may designate, to perform and administer all treatments and diagnosis, which in their fair judgment may be considered necessary or advisable for the patient's well-being.

<u>Release of Information:</u> I hereby authorize Low Testosterone Men's Clinic, L.P. or associated in charge of my care to release information contained in my medical records to the insurance company or companies, agents or independent contracts thereof, for the purpose of processing my claims for insurance benefits.

<u>Financial agreement:</u> The undersigned hereby agrees that in consideration for services rendered, payment of the account is guaranteed in accordance with the regular rate and terms of Low Testosterone Men's Clinic, L.P. The undersigned clearly understands that payment obligation is the responsibility of the patient and or undersigned.

<u>Assignment of benefits:</u> I hereby assign to Low Testosterone Men's Clinic, L.P. or associates with my care and treatment any interest and/or benefits provided under my insurance policy or policies. I also understand that any balance not covered by insurance is due and payable by me.

_____ _____

Patient or Representative/Relation **Date**

_____ _____

Witness **Date**

NO SHOW/MISSED APPOINTMENT POLICY

In order to continue to provide a high quality of service to all of our clients, we would like to remind you of our policies and procedures listed below.

- Please arrive on time. Each patient is scheduled for a specific time for their visit.

- As a courtesy, an appointment reminder email or text is attempted 1 day prior to you scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

- Please cancel your appointment with at least a 24 hours notice. We will be glad to assist you to reschedule this appointment if needed.

- If you do not present to the office for your appointment, this will be documented as a "No-Show" appointment.

- After the first "No-Show/Missed" appointment, you will receive a REMINDER that you have broken our "No-Show" policy. We will be glad to assist you to reschedule this appointment if needed.

- If you have 2 "No-Show/Missed" appointments within a one-year time period, you will receive a warning letter from our office and will be assessed a $25.00 no show fee.

- If you have 3 "No-Show/Missed" appointments within a one-year time, you will receive a second $25 no show fee assessment.

I have read and understand LT Men's Clinic No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify the office appropriately if I have difficulty keeping my scheduled appointments.

NAME_____ DATE_____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+
		TOTAL:		

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

Patient name:_____

Consent for Telemedicine

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to all eligible providers from LT Men's Clinic to provide health care services to me via telemedicine.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit.

I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting LT Men's Clinic at 817-416-5698. As long as this consent is in force (has not been revoked) any eligible provider at LT Men's Clinic may provide health care services to me via telemedicine without the need for me to sign another consent form.

Signature of Patient (or person authorized to sign for patient): _____ *Date:* _____

If authorized signer, relationship to patient: _____

Witness: _____ *Date:* _____

Male Initial Intake Form

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

Past Medical History:

Date of Last: Physical Exam _____Eye Exam _____Dental Exam_____

Please check any of the following illnesses that you currently have:

□ Asthma	□ Breast disease	□ Cancer
□ Diabetes	□ Elevated cholesterol	□ Fibromyalgia
□ Gallbladder disease	□ Heart disease	□ High Blood Pressure
□ Migraines	□ Mitral valve prolapse	□ Thyroid problems
□ Kidney infections/stones	□ Low Testosterone	□ Low vitamin D

Please list any diagnoses not listed above:

_____

_____

Please list any medications you are currently taking:

Medication Name	Dose	Medication Name	Dose

Have you ever had a bone density scan performed? _____ If so, when? _____

Have you had a screening colonoscopy? _____ When? _____ Normal or Abnormal?

Allergies:

Please list any medications/substances you are allergic to and your reaction:

_____

_____

Past Surgical History:

Please list any surgeries and the date of the surgery below:

_____

_____

Family History: (list details about your family medical history if known)

_____

_____

Vaccination History:

Please identify the vaccinations you have received in the past and the date last administered.

□ Influenza	□ HPV	□ Pneumococcal 13	□ Pneumococcal 23
□ Td/Tdap (Tetanus)	□ Zoster	□ Meningococcal	□ Hepatitis A
□ Varicella	□ MMR	□ Hepatitis B	□ Other:

Social history:

Do you smoke? _____ If yes, how many packs per day? _____

If you are a former smoker, when did you quit? _____

Do you consume alcohol? _____ If so, how much and how often? _____

Do you use any recreational/illicit drugs? _____

Do you use a seatbelt? _____

Are you currently sexually active? _____ How many partners in the last year? _____

Do you exercise regularly? _____

On average how many hours of sleep do you get a night? _____

Do you follow any special diet? _____ If yes, please describe: _____

Occupation: _____

Marital status: □ single □ married □ domestic partnership □ separated □ divorced □ other

Past History

YES NO Have you had a significant head injury?

YES NO Have you had a significant testicular injury?

YES NO Have you used steroids in the past?

YES NO Have you ever been diagnosed with sleep apnea?

YES NO Do you use pain medication regularly?

YES NO Have you ever been treated with chemotherapy or radiation?

YES NO Have you ever had an abnormal PSA(prostate) test?

YES NO Have you ever had prostate or breast cancer?

YES NO Have you ever had any surgery in the prostate or the genital area(Vasectomy/hernia repair)?

YES NO Have you been told that you have erythrocytosis (thickening of blood)?

YES NO Are you being treated for benign prostatic hypertrophy?

YES NO Do you have liver disease/damage?

Family History:_____

YES NO Do you have any blood related family with prostate cancer? If yes, who_____

YES NO Do you have any blood related family with other cancers? If yes, which_____

General- □ Fatigue □ Sleeping more than usual □ Weakness □ Cry easily/often □ Aches/Pains

Genital Male- □ Low libido(desire) □ Poor erection □ Cannot sustain an erection □ Deformity of erection □ Decreased testicular size □ Pain □ Penile discharge □ Premature ejaculation □ Less waking erections

Psychiatric- □ Depression □ Moodiness □ Anxiety □ Sleep problems □ Trouble falling asleep □ Trouble staying asleep □ Loss of appetite □ Suicidal thoughts

Endocrine- □ Weight gain/loss □ Excessive sweating □ Excessive thirst □ Excessive urination □ Heat or cold intolerance □ Loss of hair to underarms and genitals □ Hot flashes

Eyes- □ Vision change □ Loss of partial vision □ Flashing lights □ Spots in visual

Cardiovascular- □ Chest pain or discomfort □ Palpitations □ Swelling

Breast- □ Breast enlargement □ Breast tenderness □ Masses/Lumps

Neurologic- □ Headaches □ Decreased memory □ Decreased concentration □ Seizures

Osteoporosis evaluation- □ Broken bones without injury □ Decrease in height

Do you want to have any more children? YES NO

Do you currently have a primary care physician? YES NO

Please list any specific concerns you have regarding your healthcare today:

_____
_____
_____
_____
_____
_____
_____
_____