REGISTRATION FORM

Today's Date:

PATIENT INFORMATION

First Name:	Middle:	Last:	Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed

Email:	D.O.B.	Age:	Sex: [ ] Male [ ] Female

Street Address:

City:	State:	Zip Code:

Home phone:	Cell phone:	
Occupation:	Employer:	Employer phone:

Referred by / How you heard about us:

Other family members seen here:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship:	Cell phone:

Patient/Guardian signature

Date

General Consent for Care and Treatment Consent

TO THE PATIENT:

You have the right, as a patient, to be informed about your condition and the recommended Diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary examinations, testing and treatment. By signing below, you are indicating that:

(1) You intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended

(2) You consent to treatment at this office or any other satellite office under common ownership.

The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your practitioner about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request the health care providers or the designees as deemed necessary, to perform reasonable and necessary examination, testing and treatment for the condition which has brought me to seek care at this practice.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative____

Printed Name of Patient or Personal Representative ____

Relationship to Patient___________________________________*Date*_______________________________

Cancellation Policy

If you need to cancel or reschedule an appointment, please give 24 hours advance notice to ensure you will not be charged for the appointment. If less than 24 hours notice is given and we are unable to fill your time slot, you will be charged for the appointment. (Remember, our confirmation texts do not receive replies. You must call or email to change or cancel an appointment.)

Return Policy

All supplement sales are final.

I have read and understand the Cancellation and Return Policies.

Signature of Patient or Personal Representative

____

NOTICE OF PRIVACY PRACTICES

Effective January 2003

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read carefully.

Your Health Information & Rights

Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment and a plan for future care or treatment. This information is referred to as your health or medical record. This Notice of Privacy Practices describes how we use or disclose your health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law.

Although your health records are the property of the practice, this information belongs to you. You have the right to:

1. Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
2. Obtain a paper copy of this notice of privacy practices
3. Inspect and request a copy of your medical record as provided for in 45 CFR 164.524
4. Amend your health record as provided in 45 CFR 164.526
5. Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
6. Request communications of your health information by alternative means and locations

Living Health's Responsibilities:

1. Maintain the privacy of your health information
2. Provide you with this notice as to our legal duties and privacy practices with respect to your health information
3. Abide by the terms of this notice
4. Notify you if we are unable to agree to a requested restriction

We reserve the right to change our privacy practices and to make the new provisions effective for all protected health information we maintain. The current Notice of Privacy Practices can be reviewed by contacting us and requesting that a revised copy be sent to you in the mail. We will not use or disclose your health information without your authorization, except as described in this notice.

<u>For more information or to report a problem:</u>

If you have questions and would like additional information, you may contact the office at (830) 632-5906. If you believe that your privacy rights have been violated, you can file a complaint with the secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment and Health Care Operations:

Living Health will use your health information for treatment. Your health information may be released to other healthcare professionals with the hospital and the community for the purpose of providing you with quality healthcare. For example: information obtained by one of our staff including providers, nurses and administrative staff will be recorded in your record and used to determine the course of treatment that should work best for you. We will also provide your physician or a subsequent healthcare provider, such as a nursing home, home health care agency or physical therapy office, with copies of various reports that will assist them in treating outside of this office as necessary.

We will use your health information for payment. For example: a bill may be sent to your insurance company or other third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, tests and supplies used in the course of your care in our office.

If you understand the above notice and information contained within, we ask that you sign and date that you acknowledge receipt of this information from our office. We will keep a copy of this signed notice in your medical record and provide you a copy for your own records if requested.

Disclosures

Business Associates: There are some services provided in our clinic through contracts with business associates. Examples include physician services in the emergency department and radiology, certain lab tests, transcription services and billing companies. Through a signed agreements, we require all business associates to comply with HIPPA laws and requirements to safeguard your health information.

Notification: We may use or disclose information to notify a family member, personal representative, or other person responsible for your car, your location and general condition.

Communication with Family: Our staff, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Food & Drug Administration: We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized to comply with Texas laws relating to the workers compensation program.

Public Health: As required by Texas law we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.
Communicable Disease: We may disclose health information as required by Texas law to a person who may have been exposed to communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Abuse or Neglect: We may disclose health information to a health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your health information if we believe that you have been a victim of abuse, neglect, or domestic violence to the government agent authorized to receive such information.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Marketing & Patient Satisfaction Surveys: We may contact you to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you. We may also contact you to obtain your opinion about our services.

Law Enforcement: We may disclose health information for law enforcement purposes as required by Texas law or in response to a valid subpoena or court order.

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Military & Veterans: If you are a member of the armed services, we may disclose health information as required by military command authorities.

Signature of Patient (or legal representative) Date

CONSENT FOR BIO-IDENTICAL HORMONE REPLACEMENT THERAPY

You have been diagnosed with or have an increased risk of having a hormone deficiency(s) and your doctor has recommended treatment with bio-identical hormone replacement therapy (BHRT). Some of the Bio-Identical hormone preparations that may be prescribed for you are compounded. The use of this therapy as it relates to your diagnosis, while common in alternative and weight loss practices, may be debated in the traditional medical community.

You have the right, as a patient, to be informed about your condition and the recommended conventional, integrative, complementary, alternative, non-conventional or non-standard procedures to be used so that you make an informed decision whether or not to undergo the procedures after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may have the information needed to give or withhold your consent to the procedure or treatment.

Therapeutic Basis: Many individuals have inadequate hormone levels despite technically normal blood tests. Some individuals suffering symptoms related to menopause or andropause or inability to lose weight may also benefit from these therapies. Bio-identical hormone replacement therapy can be used to augment hormone levels in a number of conditions where diminished hormone levels are evident.

- Estrogen therapy can maintain vaginal and urethral function and slow the progression of osteoporosis. It may also improve sleep, decrease pain and perhaps cognitive function, and improve libido and overall well-being. This therapy may contain one or any combinations of the following medications: estriol, estradiol, and/or estrone.
- Progesterone hormone replacement therapy can offer protection from endometrial cancers, treatment of irregular menstruation, and other low progesterone conditions. It also can improve sleep quality and decrease anxiety. For males, low dose progesterone therapy in conjunction with testosterone therapy can maximize the hormone ratios, reducing side effects.
- Testosterone replacement therapy is used to treat symptoms or lab tests suggesting suboptimal hormone levels as determined by your doctor. Low testosterone is associated with elevated cholesterol, blood pressure, diabetes and prostate problems. There are ongoing discussions within the medical community whether treating to optimize testosterone will increase or decrease these problems.
- DHEA is the abbreviated form for a chemical called dehydroepiandrosterone, a hormone produced within the body. DHEA is a hormonal precursor responsible for producing both testosterone and estrogen.
- **Nutritional Supplements:** May be recommended to optimize nutritional status and augment benefits of your treatment recommendations.

Objectives: Bio-identical hormone replacement therapy is implemented to optimize hormone levels in the blood, helping to reduce symptoms associated with low levels of these hormones.

Potential Risks:
Safety of any of these hormones during pregnancy cannot be guaranteed. Notify your physician or if you are pregnant, suspect that you have become pregnant, or if you are planning to become pregnant during this therapy.

Estrogen Therapy: Bio-identical estrogens are available in various forms including oral capsules, troches, patches and topical creams. Adverse reactions may include bloating, breakthrough bleeding, breast swelling and tenderness, fluid retention, weight gain, liver cysts, death (e.g.-from blood clots or cancer) and mood swings.

High potency conjugated estrogens (e.g. Premarin), and perhaps even estradiol, have been associated with an increased risk of breast cancer and blood clots (the latter especially in smokers). Estriol may carry a lower risk of breast cancer and may even protect against breast cancer. Nonetheless, the whole

area of estrogen replacement is undergoing further evaluation. Do not take estrogen if you have breast cancer.

Progesterone Therapy: Bio-identical progesterone is available in various forms including oral capsules, troches, vaginal or rectal suppositories, and topical creams or gels. Progesterone therapy may be sedating, so it is recommended to coordinate dosing with sleep cycle. Adverse reactions may include bloating, breakthrough bleeding, missed menstrual cycles, breast swelling and tenderness, fluid retention, weight gain, sedation, and depression.

Testosterone Therapy: Bio-identical testosterone therapy is available in various forms including sublingual drops, troches, topical creams, and injection. Side effects include acne, chronic priapism (persistent, abnormal erection of the penis), change in libido, angina or heart attacks, hirsutism (facial hair growth) and scalp hair loss, clitoral engorgement, voice changes, or water retention. Because it may improve insulin resistance in males, diabetics who use insulin should monitor glucose levels closely, as less insulin may be needed. Check with your physician before adjusting your dose of insulin. If using a formulation of testosterone that is applied to the skin, a local irritation may occur. In women, excessive testosterone or DHEA doses could increase the risk of diabetes or facial hair.

Although the use of bio-identical hormone replacement therapy has been shown in many studies to be safer than synthetic hormone replacement therapy, the risk of cancer-related side effects is still possible. In fact, there are physicians who do not agree with use bio-identical hormones

Statement of patient:
I understand that along with the benefits of any medical treatment or therapies, there are both risks and potential complications to treatment, as well as not being treated. Those risks and potential complications have been explained to me. I have not been promised or guaranteed any specific benefit from the administration of these therapies and no warranty or guarantee has been made regarding the results of treatment. I agree to proceed with treatment and to comply with recommended dosages.

I agree to comply with requests for ongoing testing to assure proper monitoring of my treatments that may include laboratory evaluation of all aforementioned hormone levels or other diagnostic testing by a Living Health physician, my primary care physician, or other specialist. I agree to see my primary care physician, gynecologist, or other practitioner for regular monitoring and for preventative measures that may include but are not limited to complete physicals, rectal examinations and/or colonoscopy, EKG, mammograms, pelvic/breast exams, pap smears, prostate exams, PSA levels, etc. at least on a yearly basis.

I agree to immediately report to Living Health any adverse reaction or problem that might be related to my therapy. I understand that along with the benefits of any medical treatment or therapies, there are both risks and potential complications to treatment, as well as to not being treated. Those risks and potential complications have been explained to me and I agree that I have received information regarding those risks, potential complications and benefits, and the nature of Bioidentical and other hormone treatments and have had all my questions answered. Furthermore, I have not been promised or guaranteed any specific benefit from the administration of bio-identical hormone therapy.

I certify this form has been fully explained to me, that I have read it or have had it read to me and that I understand its contents. I agree not to undergo any treatments unless I fully understand the treatment and have discussed possible risks and benefits.

I agree to the therapy described above. I have been educated on the benefits, risks, and possible adverse reactions associated with bio-identical hormone replacement therapy.

Signature of Patient ____ Date_________________________

Name (PRINT) ____

Witness____

Male Symptoms Questionnaire

Patient Name: ____________________________ALLERGIES: _________________________________

Please circle a number from each symptom describing how you CURRENTLY feel

	Low-------Moderate-------Severe	Comments, if any
Sleep Disturbances	0 1 2 3 4 5 6 7 8 9 10	___________________________
Sex Drive	0 1 2 3 4 5 6 7 8 9 10	___________________________
Erectile Dysfunction	0 1 2 3 4 5 6 7 8 9 10	___________________________
Prostate problems	0 1 2 3 4 5 6 7 8 9 10	___________________________
Exercise Tolerance	0 1 2 3 4 5 6 7 8 9 10	___________________________
Loss of Muscle Tone	0 1 2 3 4 5 6 7 8 9 10	___________________________
Poor Focus	0 1 2 3 4 5 6 7 8 9 10	___________________________
Mood Swings	0 1 2 3 4 5 6 7 8 9 10	___________________________
Depression	0 1 2 3 4 5 6 7 8 9 10	___________________________
Hair Loss	0 1 2 3 4 5 6 7 8 9 10	___________________________
Headaches	0 1 2 3 4 5 6 7 8 9 10	___________________________
Weight Gain	0 1 2 3 4 5 6 7 8 9 10	___________________________
Fatigue	0 1 2 3 4 5 6 7 8 9 10	___________________________
Digestion(bloating)	0 1 2 3 4 5 6 7 8 9 10	___________________________
Body or Joint Pains	0 1 2 3 4 5 6 7 8 9 10	___________________________
Constipation	0 1 2 3 4 5 6 7 8 9 10	_________________________

Any Changes in your History & Physical _____Yes_____No

Any Changes in medications _____Yes_____No

Patient Signature: ____

Date:____________________________

Health History Questionnaire

Name: **Date:**

Main problem(s) with which you would like help
Problem or Disease:
Past Medical History (please include dates)
Significant Illnesses (circle): Cancer, Diabetes, Hepatitis, High Blood Pressure, Heart Disease, Rheumatic Fever, Thyroid Disease, Seizures, Venereal Disease Other:
Have you been vaccinated for childhood diseases? Yes No
Surgeries:
Significant Trauma (auto accidents, falls, etc.)
Birth History (prolonged labor, forceps delivery, etc.):
Allergies (drugs, chemicals, foods):

Family Medical History
☐ Diabetes ☐ Cancer ☐ High Blood Pressure ☐ Seizures ☐ Asthma ☐ Allergies ☐ Stroke ☐ Heart Disease Other:________________________
Occupation:
Occupational Stress (chemical, physical, physiological. Etc.) Do you have a regular exercise program? Please describe.

Medicines taken within the last two months (Include vitamins, over-the-counter drugs, herbs, etc)
Are you now or have you ever been on a restricted diet? _____ What kind? __________________ Please describe your average daily diet: Morning: Afternoon: Evening:
How many packs of cigarettes a day do you smoke? _____ How much coffee, tea or cola do you drink per week? ____ How much alcohol do you drink per week? ____ Please describe any use of drugs for non-medical purposes:

General

- ☐ Poor Appetite
- ☐ Poor Sleeping
- ☐ Fatigue
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Sweat Easily
- ☐ Tremors
- ☐ Cravings
- ☐ Localized Weakness
- ☐ Poor Balance
- ☐ Change in appetite
- ☐ Bleed or Bruise Easily
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Peculiar Tastes or Smells
- ☐ Strong Thirst (cold or hot drinks)
- ☐ Sudden Energy Drop (What time of day?) ____________________

Skin and Hair

- ☐ Rashes
- ☐ Ulcerations
- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Pimples
- ☐ Dandruff
- ☐ Loss of Hair
- ☐ Recent Moles
- ☐ Change in Hair or Skin Texture

Any Other hair or skin problems? ____

Head, Eyes, Ears, Nose and Throat

- ☐ Dizziness
- ☐ Concussions
- ☐ Migraines
- ☐ Glasses
- ☐ Eye Strain
- ☐ Eye Pain
- ☐ Poor Vision
- ☐ Night Blindness
- ☐ Color Blindness
- ☐ Cataracts
- ☐ Blurry Vision
- ☐ Earaches
- ☐ Ringing in Ears
- ☐ Poor Hearing
- ☐ Spots in Front of Eyes
- ☐ Sinus Problems
- ☐ Nose Bleeds
- ☐ Recurrent Sore Throats
- ☐ Grinding Teeth
- ☐ Facial Pain
- ☐ Sores
- ☐ Teeth Problems
- ☐ Jaw Clicks
- ☐ Headaches (Where and When?) ______________________

Any other head or neck problems? ____

Cardiovascular

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ Dizziness
- ☐ Fainting
- ☐ Cold Hands or Feet
- ☐ Swelling of the Hands
- ☐ Swelling of the Feet
- ☐ Blood Clots
- ☐ Phlebitis
- ☐ Difficulty in Breathing

Any other heart or blood vessel problems? ____

Respiratory

- ☐ Cough
- ☐ Coughing Blood
- ☐ Chest Pain
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Pain with a Deep Breath
- ☐ Difficulty in Breathing when Lying Down
- ☐ Production of Phlegm (What color?)

Any other lung problems? ____

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas
- ☐ Belching
- ☐ Black Stools
- ☐ Blood in Stools
- ☐ Indigestion
- ☐ Bad Breath
- ☐ Rectal Pain
- ☐ Hemorrhoids
- ☐ Abdominal Pain or Cramps
- ☐ Chronic Laxative Use

Any other problems with your stomach or intestines? ______________________________

Genito-Urinary

- ☐ Pain on Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Urgency to Urinate
- ☐ Unable to Hold Urine
- ☐ Kidney Stones
- ☐ Decrease in Flow
- ☐ Impotence
- ☐ Sores on Genitals

Do you wake up to urinate? ______ How often? ____________________

Any particular color to your urine? ______________

Any other problems with your genital or urinary system? ____________________

FEMALE ONLY SECTION: Pregnancy and Gynecology

____ Number of pregnancies ____ Number of Births ____ Premature Births

____ Miscarriages ____ Abortions ____ Age at first Menses

____ Period between menses ____ Duration First date of last menses ________

- ☐ Unusual Character (Heavy or Light)
- ☐ Painful Periods
- ☐ Clots
- ☐ Last PAP
- ☐ Vaginal Discharge
- ☐ Vaginal Sores
- ☐ Breast Lumps
- ☐ Changes in body / psyche prior to menstruation

Do you practice birth control? _____ What type and for how long? ____________

Musculoskeletal

- ☐ Neck Pain
- ☐ Muscle Pains
- ☐ Knee Pain
- ☐ Back Pain
- ☐ Muscle Weakness
- ☐ Foot / Ankle Pains
- ☐ Hand / Wrist Pains
- ☐ Shoulder Pain
- ☐ Hip Pain

Any other joint or bone problems? ____

Neuropsychological

- ☐ Seizures
- ☐ Dizziness
- ☐ Loss of Balance
- ☐ Areas of Numbness
- ☐ Lack of Coordination
- ☐ Poor Memory
- ☐ Concussion
- ☐ Depression
- ☐ Anxiety
- ☐ Bad Temper
- ☐ Easily Susceptible to Stress

Have you ever been treated for emotional problems? _____

Have you ever considered or attempted suicide? _____

Any other neurological or psychological problems? ________________________