MENS T CLINIC

Patient Information

Patient Name: _____
Last First Middle

Current Address: _____

Zip Code: _____ City: _____State_____

Home Phone #:_____Work Phone #: _____

Cell Phone #: _____ Email Address: _____@_____

Date of Birth: _____/_____/_____ Social Security #: _____

Sex (circle one): Male / Female How did you hear about us? _____

Marital Status (circle one): Single / Married / Divorced / Widowed / Other

Patient Relationship to the Responsible Party: Self / Spouse / Child / Other

Primary Care Physician: _____

Patient's Employer Information: _____

Name of company and address: _____

Primary Insurance

Primary Insurance Company: _____

Address: _____ Phone #_____
(will be located on the back of the insurance card)

Subscriber's Name: _____Member Id #: _____

Group Name: _____Group Number: _____

Patient Relationship to subscriber (circle one): Self / Spouse / Child / Other

MENS T CLINIC

INSURANCE POLICY

Insurance provides your reimbursement on allowed medical charges. As a courtesy to you the office will file your medical claim with your insurance company for reimbursement of your office visit, outpatient procedure or any other medical services you may receive from the Men's T Clinic. We will also provide you with an itemized statement for your records. Although, we do file your insurance claims for reimbursement, **it is up to you as the patient (insured) to pay any and all outstanding co-pays, deductibles, percentages of your balance.** You are expected to pay any co-pays, deductibles, co-insurance at the time services are rendered. The office will verify your insurance and confirm your copays, deductibles, co-insurance and will advise you of those totals upon your visit. It is also up to you as the patient to **provide the office with the most current and accurate insurance information, address, phone number or name changes**. Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, or payments from the insurance company, this is your responsibility.

OFFICE POLICY ON PAYMENT

It is our policy to require payment of all office charges at the time they are rendered. If you have an outstanding balance, that balance must be brought current or a payment plan must be worked out. All uninsured patients must pay in cash. If you have a check returned you will also be responsible for all future payments to be paid in cash or credit card only.

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

I have read the above and accept financial responsibility in full for this account.

_____ _____/_____/_____

Patient, Parent, Guardian Signature **Date Signed**

In case of an emergency please contact:

Name: _____ Relationship:_____

Address: _____

Phone #: _____

MENS T CLINIC

FINANCIAL AGREEMENT

Thank You for selecting the Men's T Clinic as your healthcare provider. We are committed to provide you with the best possible care. If you have medical insurance, we strive to help you receive your maximum allowable benefits. In order to achieve these goals we need your assistance and your understanding of our payment policy, which we require you to read and sign prior to any treatment.

Payment Methods- Payment is expected at the time services are rendered. We accept cash, money order, VISA, MasterCard. We will now be collecting your co-pays and deductible (if applicable) upon your office visit and you will be expected to pay your co-pay/co-insurance.

Insurance Information- We must emphasize that you are the insured party. Because your insurance policy is a contract between you and your insurance company, please check with your insurance carrier to determine any pre-existing limitations or other benefit restrictions that you may have, prior to your appointment. We will file your insurance as a courtesy and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. **Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim or not. To avoid any issues with this insurance policy, please provide us with the most up to date insurance information you have at each clinic visit.**

Lab/Diagnostic Services- It is office policy that patients will be subject to lab tests at any/all office visits. You may receive a separate bill for these services. As the patient, you are financially responsible for any co-pay or balances due for these services if they are not reimbursed by your insurance for any reason.

Uninsured- A **minimum payment of $250.00 cash for a new patient is due at the time services are rendered if you qualify for TRT (Testosterone Replacement Therapy).** This fee will be up front and **each office visit will be a $100 fee.** (Includes any outside lab work & injection) Also, weekly therapy is deemed appropriate for you this fee may go up.

Private Insurance-Typically this type of **plan pays percentage of the contracted amount after the deductible has been met**. Our business office will file your charges with your carrier. Any amount not paid by the carrier will be your responsibility to pay.

Contractual Agreements- (PPO's, HMO's), generally a co-pay is required at the time services are rendered. Not all services are a covered benefit in all contracts. **Some insurance companies arbitrarily select certain services they will not cover. You are responsible for all non-covered services.**

Insurance Changes- If there are any changes to your insurance coverage, please provide our office with that information within 24 hours of change. **If you fail to provide us with correct information you will be responsible for the entire balance.**

Returned Checks- A $35.00 cash fee will be charged for any returned checks. **We will be unable to accept your checks for any future services.**

Our billing service is provided through **Strivant Health** and can be reached at **214-506-2610**. They will be able to provide assistance with your account. We must emphasize that as your medical care provider, our relationship is with **YOU**, not your insurance company. Although, we will file your charges with your insurance carrier, please keep in mind that you are deemed responsible for any and all charges not paid for or covered by your insurance company.

Questions or concerns regarding your account or insurance claim should be directed to our billing company at **214-506-2610**
I have read, understand and agree to this Financial Agreement

Patient Signature: _____ **Date**: _____/_____/_____

Patient Name: _____

Consent for Testosterone Replacement Therapy. There are risks associated with Testosterone Replacement Therapy and you need to be aware of them. The goal of the Men's T Clinic is to individualize your therapy. As with all prescription medication there are possible side effects. These side effects can usually be very easy to manage and your provider will discuss with you all of your options should you experience any of the listed issues below. You always have the option to consult your personal physician before deciding on whether this treatment is right for you. It is important to note that everyone responds differently to therapy. Some people may not experience any of the following side effects while others may experience one or more of the following side effects. **Please initial next to each potential side effect listed and please bring any questions to the healthcare provider**. Take all the time you need to discuss the benefits and side effects of therapy.

_____ 1. I consent to have the Men's T Clinic, including any provider or MA that works for the company, to begin treatment for Testosterone Replacement Therapy.

_____ 2. It has been explained to me and I understand that I may experience the following **side effects**:

- **Acne**
- **Breast Enlargement**
- **Mood Swings**
- **Extra Fluid in the Body (may cause problems with patients with heart, liver, or kidney disease)**
- **Sleep Disturbance I.E. Sleep Apnea**
- **Prostate enlargement could cause problems urinating**
- **Changes in cholesterol levels, red blood cell counts, PSA levels, liver function enzymes, and other hormone levels**

_____ 3. I will periodically have blood tests performed to monitor my levels.

_____ 4. I have been informed that the benefits of therapy are not guaranteed and if I stop treatment my condition may return or get worse.

_____ 5. I was given the opportunity to discuss my complete past medical history with the health care providers at Men's T Clinic. I am satisfied with our discussion.

_____ 6. The physical exam performed by Men's T Clinic does not replace the yearly exam performed by my personal physician.

_____ 7. I agree to have my personal physician perform a yearly full physical exam including a rectal exam, lipid profile, cholesterol levels, and a comprehensive metabolic panel. If I do not have a personal physician, the Men's T Clinic will assist in locating one for me.

Patient Signature	**Date**
Witness Signature	**Date**

NOTICE OF PRIVACY PRACTICES

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

The Men's T Clinic is issuing this Notice of Privacy Practices about the information we share and your legal rights and our common duties with respect to your health information.

OUR PLEDGE TO YOU

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care, bill for your care, and comply with legal requirements. This notice applies to all the records of your care that we maintain, whether made by our staff and authorized trainees, or by your personal doctor. This tells you about the ways in which the Men's T Clinic may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe our obligations regarding the use and disclosure of your health information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The Men's T Clinic doctors, nurses, pharmacists, laboratory technicians, and other health care professionals may use health information about you to provide you with health care treatment or services. We may also disclose health information about you to others who are involved in taking care of you**.** For example, we may send health information about you to a specialist as part of a referral.

The Men's T Clinic may use and disclose health information about you to obtain payment for the treatment and services you receive from us. For example, we may send billing information to your insurance company or Medicare. We may also tell your insurance company about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. The Men's T Clinic may send you a statement of your account if payment is due from you. We may send the guarantor (responsible party for payment) monthly statements for charges for all patients under that guarantor.

The Men's T Clinic may use and disclose health information about you to support our health care operations. For example, we may use health information to review the treatment and services and to evaluate the performance of our staff in caring for you. We may combine health information about many patients to decide what additional services we should offer. We may remove information that identifies you from this set of health information so others may use it to study health care delivery without learning who our specific patients are.

We may disclose information to notify a family member or other person responsible for your care about your condition, status, and location.

NOTICE OF PRIVACY PRACTICE CONTINUED

If you are admitted and unless you tell us otherwise, we may provide your name, location in the hospital, and your general condition (good, fair, etc.) for information to be included in a patient directory and make this information available to anyone who asks for you by name.

We may use and disclose health information to contact you for an appointment reminder, to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you, or to contact you about support our fund-raising efforts.

Subject to certain requirements, we may use or disclose health information about you without your prior authorization for other reasons:

We may give out health information about you for public health purposes; to report abuse or neglect; for health oversight reviews; in research studies; for funeral arrangements and organ donation; in response to special law enforcement requests, valid judicial or administrative orders, or for authorized national security and intelligence activities; for workers' compensation purposes; to avert a serious threat to your health or safety or those of the public or another person; and when required by law. If you are or were a member of the armed forces, we may release information about you as required by military command authorities or the Department of Veterans Affairs. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official.

In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing your health information. You may revoke this authorization for any subsequent disclosures by notifying us in writing.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the right to request in writing that you inspect and obtain a copy of the health information that we use to make decisions about your care. We may charge a fee for the costs of copying, mailing or other supplies and services associated with your request. If we deny your request to inspect or obtain a copy in certain limited circumstances, you may request that the denial be reviewed. Another licensed health care professional chosen by The Men's T Clinic will review your request and the denial and we will comply with the outcome of that review.

If you believe that health information we have about you is incorrect or incomplete, you may make a written request to ask us to amend information. The request should state the reason for the amendment and specific information to be amended. The amendment must be limited to one page. Any amendment we make to your information will be disclosed to those with whom we disclose information as previously noted.

We may deny your request for an amendment if the information be amended was not created by us, is no longer maintained by us, is not part of the information which you would be permitted to inspect and copy; or is accurate and complete. We will notify you if we deny your request for amendment and you may appeal, in writing, our decision. Any statements of disagreement or rebuttal will be linked to your health information and made a part of any subsequent disclosure we make of such information.

NOTICE OF PRIVACY PRACTICE CONTINUED

You have the right to make a written request for a list of disclosures we have made of your health information, except for uses and disclosures for treatment, payment, and health care operations, as previously described, and those for which you have authorized disclosure. Your request must state a time period which may not be longer than six years and may not include date May 1st, 2014. We will not charge you for the first list you request within a 12-month period, additional requests will be charged according to our cost for producing 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.

You have the right to request a restriction on the health information we use or disclose about you for treatment, payment, or health care operations. There may be risks associated with such restrictions and we may ask you to acknowledge these risks in writing for certain requests you may make. We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively impact the care we may provide you. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

You have the right to request, in writing without requiring you to state a reason, that confidential communications with you be made in an alternative manner or location. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

WRITTEN REQUEST: If you have any questions about this notice, please contact: The Men's T Clinic, 4815 SH 121 #5, The Colony, Texas 75056: Phone: 972-865-6356

COPIES OF NOTICE AND CHANGES

You have the right to obtain a paper copy of this notice at any time. We reserve the right to change this notice, and to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future.

MENS T CLINIC

Office Use Only

Patient Name: _____ **Date of Birth:** ____/____/____ **Date of Visit:** ____/____/____

Weight: _____**lbs.** **BP:** _____ / _____ **HR:** _____ **RR:** _____

What brings you in (Circle all that apply):

Decreased libido Decreased mental clarity Fatigue Moodiness Weight gain

Other: _____

Please circle the symptoms that describe what you are feeling:

- decreased libido
- decreased spontaneous erections
- breast discomfort
- enlarged or "swollen" breasts
- hot flushes
- unusual sweating
- loss of axillary or pubic hair
- noticeable decrease in testicular size
- testes that are less than 2.5cm

Please circle any of the additional symptoms, to those above, you may be experiencing:

- Weight gain: If so, how much, over what period of time? _____
- Decrease in muscle size, strength, or tone.
- Decline in physical performance/capabilities over the last few years.
- Increased blood pressure over the last few years.
- Increased blood sugar.
- Decreased mental sharpness.
- Decreased morning erections.
- Erectile dysfunction
- Snoring
- Night time awakenings, gasping for air.

How long have the above symptoms been occurring? (Circle one)

Less than 1 year / Approximately 1 year / 2-3 years / 4-5 years / > 5 years

What is the duration of your symptoms/timing? (Circle one)

- All day/constant
- In the morning only, then improves as the day goes on
- The afternoon seems to be the worst time of day for my symptoms
- Variable

How would you describe these symptoms, and their effect on your quality of life? (Circle one)

- Mild
- Moderate
- Severe

Do any of the below improve your symptoms? (Circle any that apply)

- Caffeine
- Exercise
- Sleep
- Testosterone
- Testosterone boosters
- None

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Past Medical History: (Circle all that apply)

- Hypogonadism
- Prior testosterone replacement/use
- Hypothyroidism
- Enlarged thyroid
- Diabetes type I
- Diabetes type II
- Obesity
- Sleep apnea
- High blood pressure
- High cholesterol
- Peripheral artery disease
- Acid reflux
- Abnormal liver functions
- Chronic kidney disease
- Enlarged prostate (BPH)
- Personal history of prostate cancer
- Inability to father children despite unprotected sexual relations for more than 1 year
- Chronic lymph node enlargement
- Anemia
- Hemochromatosis
- Personal history of mumps
- HIV
- Anxiety (treated with medications)
- Depression (treated with medications)
- Cotton seed allergy
- None

Have you had any of the following cardiac disorders/events: (circle all that apply)

- Heart attack
  Date: _____
- Stroke
  Date: _____
- Blood clot (either DVT or pulmonary embolism)
  Date: _____
- Coronary artery bypass graft surgery (CABG)
  Date: _____
- Aortic valve disorder
- Mitral valve disorder
- Endocarditis
  Date: _____
- Pericarditis
  Date: _____
- Cardiomyopathy
- Cardiac conduction event/disorder (bundle branch block, AV block)
  Type: _____
- Cardiac arrhythmia (Atrial fibrillation/flutter, Ventricular tachycardia, etc.)
  Type: _____
- Heart failure
  Type: _____
- Prior stent placement
  Date: _____
- History of coronary artery disease, without prior event or procedure
- None

Past Family History: (Circle all that apply)

- Prostate cancer
  Relation? _____
- Breast
  Relation? _____
- Diabetes
  Relation? _____
- Hypothyroidism
  Relation? _____
- Delayed puberty
  Relation? _____
- Reproductive disorder
  Relation? _____
- Heart attack
  Relation? _____
- Stroke
  Relation? _____
- None
- Unknow

Past Surgical History: (circle all that apply)

- Vasectomy
  Date: _____
- Orchiectomy
  Date: _____
- Varicocele/hydrocele repair Date: _____
- Other genital/urinary surgery Date: _____
  Date: _____
- Thyroid removal
  Date: _____
- Thyroid biopsy
  Date: _____
- Weight loss surgery
  What type: _____
  Date: _____

Do you drink alcohol? Yes / No **if yes, how many drinks per week?** _____

Do you smoke cigarettes? Yes / No **if so, how many cigarettes per day?** _____**# of years smokin**g? _____

Do you presently use: Opiate pain medications / Illicit drugs / None **If any applies what type?** _____

What is your exercise regimen? None / 1-2 days per week / 3 or more days per week

Marital Status (Circle one): Married / Divorced / Single / Widowed

Do you wish to have any more children? (Circle one): Yes / No / Uncertain

Employment: Full time / Part-time / Retired / Unemployed

What is your occupation? _____

Please list any drug allergies below OR No known drug allergies

_____

Please list any medications and/or supplements you are taking below:

_____

_____

Review of Systems: (Please circle all that apply)

Constitutional: Fatigue Abnormal weight gain Abnormal weight loss Decreased appetite Night sweats

Integumentary: Acne Recurrent rashes

Eyes: Blurry vision Double vision Visual disturbances

Ear/Nose: Hearing loss Ringing in ears Altered sense of smell

Chest: Nipple sensitivity

Respiratory: Shortness of breath Persistent nonproductive cough

Cardiovascular: Chest pain/pressure Palpitations Dizziness Fainting spells Pain in lower legs with walking

Gastrointestinal: Swallowing difficulties Heartburn Vomiting Abdominal pain Persistent nausea

Genitourinary: Urinary hesitancy Urinary urgency Urinary frequency Dribbling after urination

Pain with urination Erectile dysfunction

Musculoskeletal: Muscle pain Joint pain

Neurological: Frequent headaches Chronic pain Speech difficulties Change in sense of smell

Psychiatric: Irritability Depressed mood Frequently anxious Decreased self-confidence

Endocrine: Appetite change Increasing thirst Heat intolerance Cold intolerance

MENS T CLINIC

Mid-Level Provider Notice

Mid-Level provider (MLP) are licensed health professionals who practice medicine with physician, supervision. As part of the physician/MLP team, MLPs exercise autonomy in diagnosing and treating illnesses. MLPs deliver a broad range of medical and surgical services to diverse populations in both rural and urban settings throughout the United States. Their focus is patient care, and their practice may include education, research, and administrative activities. In most states, MLPs can treat patients when the physician is away from the practice and can write prescriptions.

MLPs are highly skilled professionals educated to use the same medical procedures as their physician counterparts. For example, MLPs take medical histories, perform physical examinations, diagnose and treat illnesses, order and interpret laboratory tests, perform minor surgery, and in most states can prescribe medications, MLPs practice in virtually every medical specialty -from family medicine to surgery. To allow the MLP/physician team to be more efficient in extending care to their patients, most states do not require the MLP and physician to be at the same location. For example, the MLP may be seeing patients in a clinic while the supervising physician is at the hospital or in a central office. All state laws require the supervising physician to be immediately available for consultation, usually by telephone, while a MLP is seeing patients. A hallmark, of mid-level provider practice is that MLPs practice as part of a team. They are educated to recognize when patients need the attention of a supervising physician or another specialist. MLPs enjoy a collegial relationship with other providers because they have demonstrated their commitment to their patients and their competence in delivering quality care.

Mid-Level provider education is modeled on that of physicians, although it is shorter. All MLP programs must meet the same stringent requirements for national accreditation. Students undergo a rigorous education to become a MLP. The typical program is 108 weeks, compared to 153 weeks for medical, school. The first year includes classroom and laboratory instruction in the medical sciences - from, anatomy to pharmacology- and medical ethics. Their second year involves structured clinical rotations, providing the MLP student with direct patient contact in medical disciplines such as family practice, internal medicine, obstetrics and gynecology, pediatrics, surgery, and emergency medicine. MLP programs are offered by medical schools, colleges and universities, teaching hospitals, and the military.

Before they can practice, graduates of accredited. MLP programs must pass a single national certification exam developed and administered by their respective National and/or State boards. Only those individuals with current certification may use the designation "Certified." To maintain certification, MLPs must earn 100 hours of continuing medical education every two years and sit for a recertification exam every ten years (physician assistants). These requirements keep them abreast of medical advances.

Today, the mid-level provider profession is ranked as one of health care's fastest-growing fields. One reason is MLPs help people use the health care delivery system more effectively and efficiently. They make quality health care more available by providing those services needed by patients in a cost-effective way to the practice. Their training as team players enables them to work with other providers to ensure appropriate patient care in all settings, MLPs, working with the supervision of physicians, deliver the highest quality of medical care.

Patient initials for acknowledgement: _____

Office Use Only:

Witness Signature: _____ Date: _____/_____/_____

Consent to Have Blood Drawn for Treatment/Testing

I authorize the medical staff at the Men's T Clinic to draw a blood sample for the purpose of checking my PSA and Testosterone levels. I also consent that my blood draw can undergo additional laboratory testing if the healthcare provider determines that it is in the best interest of my treatment.

_____ _____/_____/_____

Patient Signature **Date Signed**

Acknowledgement of Privacy Practices

Receipt of Notice of privacy practices acknowledgement: I have received or reviewed the privacy practice notice for Men's T Clinic, and understand the situation in which this practice may need to utilize or release my medical records.

_____ _____/_____/_____

Patient Signature **Date Signed**

Consent to Obtain Medication History

I authorize Men's T Clinic to obtain my medication history from the electronic medical records/electronic prescription service. This information will be used by the providers of Men's T Clinic for the sole purpose of keeping a current accurate listing of medications.

_____ _____/_____/_____

Patient Signature **Date Signed**

Office Use Only

Witness Signature: _____ **Date Reviewed**: _____/_____/_____