FEMALE PATIENT QUESTIONNAIRE

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

Date of Birth:_____ Age:_____ Occupation:_____

Home Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work:_____

Email Address:_____

How did you hear about us? Patient Name:_____ Other:_____

In Case of Emergency Contact:_____ Relationship:_____

Cell Phone:_____ Home Phone:_____ Work:_____

If you move forward with pellet therapy, do you prefer to sign a paper or electronic consent? ☐ Electronic ☐ Paper

MEDICAL HISTORY

Height:_____ Weight:_____ Last Menstrual Period:_____ Hysterectomy? ( ) No ( ) Partial ( ) Full

Do you smoke? ( ) Yes ( ) No ( ) Quit How much?_____ How often?_____ Age started?_____

Do you drink alcohol? ( ) Yes ( ) No ( ) Quit How much?_____ How often?_____ Age started?_____

Any known drug allergies: ( ) Yes ( ) No If yes please explain:_____

Current Medications and dosage:_____

_____

_____

Nutritional/Vitamin Supplements: _____

Current Hormone Replacement Therapy:_____ Past HRT: _____

Surgeries, list all and Year:_____

Other Pertinent Information: _____

Do you have a <u>personal</u> history of? **Check all that apply.**

Preventative Medical Care:
( ) Medical/GYN Exam in the last year
( ) Mammogram in the last 12 months
( ) Bone Density in the last 12 months
( ) Pelvic ultrasound in the last 12 months

High Risk Past Medical/Surgical History:
( ) Breast Cancer
( ) Uterine Cancer
( ) Ovarian Cancer
( ) Hysterectomy with removal of ovaries
( ) Hysterectomy only
( ) Oophorectomy Removal of Ovaries
( ) Prostate Cancer

Birth Control Method:
( ) Menopause
( ) Hysterectomy
( ) Tubal Ligation
( ) Birth Control Pills
( ) Vasectomy
( ) Other:_____

Medical Illnesses:
( ) High blood pressure
( ) Heart bypass
( ) High cholesterol
( ) Hypertension
( ) Heart Disease
( ) Stroke and/or heart attack
( ) Blood clot and/or a pulmonary emboli
( ) Arrhythmia
( ) Any form of Hepatitis or HIV
( ) Lupus or other auto immune disease
( ) Fibromyalgia
( ) Trouble passing urine or take Flomax or Avodart
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis)
( ) Diabetes
( ) Thyroid disease
( ) Arthritis
( ) Depression/anxiety
( ) Psychiatric Disorder
( ) Cancer Type:_____ Year: _____

_____ _____ _____
PRINT NAME **SIGNATURE** **DATE**

Patient Consent for Release of Protected Health Information (PHI)

I, _____, give my consent to Maricopa Wellness Center to release my protected health information (PHI) to include, but not limited to: physical exam results, lab results or other diagnostic studies, medication information/changes, appointments, billing information, etc. to the following individuals:

Name (Print Clearly)	**Relationship to Patient**
Name (Print Clearly)	**Relationship to Patient**
Name (Print Clearly)	**Relationship to Patient**

Consent (check ALL that apply):

I consent Maricopa Wellness Center to leave detailed messages regarding my healthcare, appointments, services, diagnostic test results or financial services at the following [check ALL that apply]:

☐ **Call** ☐ **Text** Phone: _____

☐ **Email** address: _____

This consent will expire only with written notification to office@maricopawellness.com

Patient Name (*Print Clearly*): _____

Patient Signature: _____ **Date:** _____

If a minor (under 18 years of age)

Parent or Guardian Name (*Print Clearly*): _____

Parent or Guardian Signature: _____ **Date:** _____

Maricopa Wellness Center Med Spa

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

Your Information.
Your Rights
Our Responsibilities.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide mental health care

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Address worker's compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

I acknowledge receipt and understanding of my rights.

_____ _____ _____

Print Name: Signature Date

HIPPA Information & Consent Form

The Health Insurance Portability and Accountability Act (HIPPA) provides a safeguard to protect your privacy. Implementation of HIPPA requirements officially began on April 14, 2003.

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. HIPPA 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. Client 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 as 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 persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, client records, PHI and other documents or information.
2. It is the policy of this office to remind clients of their appointments. We may do this by telephone, e-mail, US mail, text, or 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, as well as our office promotional material 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 HIPPA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies 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. We agree to provide client's access to their records in accordance with state and federal laws
7. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the client.
8. 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 HIPPA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signature:_____

Statement of Patient Financial Responsibility

Patient Name:_____ **DOB:**_____

Maricopa Wellness Center appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. We expect these payments at time of service. I agree to **Maricopa Wellness Center** the full and entire amount of treatment given to me or to the above named patient at each visit.

We only accept insurance as a form of payment for lab work. You have the choice to file with your insurance or pay our cost. If you choose to file with your insurance for lab work instead of paying our cost you are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage.

I understand and take full responsibility for any amounts not covered by my insurance provider. _____ **Initials**

We provide paperwork for some services that you can use to submit to your insurance company for reimbursement. We are unable to assist with any additional paperwork or requests made by patients or insurance providers.

Some prescriptive medication requires a payment prior to being ordered or dispensed in office. It is the responsibility of the patient to pick up the prescription from the office or personal mailbox/home. I understand there are no refunds, for any reason, on prescription medication. _____ **Initials**

I understand that refunds or credits are not permitted on **any** prescriptive medication, product, supplement or service provided by, or sold by, **Maricopa Wellness Center. All sales are final including down payments.** _____ **Initials**

I have read the above policy regarding my financial responsibility to **Maricopa Wellness Center** for providing any and all services to me, or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate.

Patient Name (Print)	**Patient Signature**	**Date**
Guarantor Name *(required for patients < 18 years)*	**Guarantor Signature**	**Date**

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call at least 24-hours prior to cancel your appointment.

I understand if I *no show* or *cancel* an appointment without notifying **Maricopa Wellness Center** within 24 hours, I will have to pay a $50 non-refundable fee, this fee will be charged to the credit card on file automatically. _____ **Initials**

I have read and understand the above information, and I agree to the terms described:

Patient Name (Print)	**Patient Signature**	**Date**
Guarantor Name *(required for patients < 18 years)*	**Guarantor Signature**	**Date**

Female MRS Checklist - BEFORE HRT

Place an "X" for EACH symptom you are currently experiencing. *Please mark only ONE box.*

☐For symptoms that do not apply, please mark NONE.

	None	Mild	Moderate	Severe	Extremely Severe
1. **Hot flashes, sweating** (episodes of sweating)	☐	☐	☐	☐	☐
2. **Heart discomfort** (unusual awareness of heart beat, heart skipping, heart racing, tightness)	☐	☐	☐	☐	☐
3. **Sleep problems** (difficulty in falling asleep, difficulty in sleeping through the night, waking up early)	☐	☐	☐	☐	☐
4. **Depressive mood** (feeling down, sad, on the verge of tears, lack of drive, mood swings)	☐	☐	☐	☐	☐
5. **Irritability** (feeling nervous, inner tension, feeling aggressive)	☐	☐	☐	☐	☐
6. **Anxiety** (inner restlessness, feeling panicky)	☐	☐	☐	☐	☐
7. **Physical and mental exhaustion** (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)	☐	☐	☐	☐	☐
8. **Sexual problems** (change in sexual desire, in sexual activity and satisfaction)	☐	☐	☐	☐	☐
9. **Bladder problems** (difficulty in urinating, increased need to urinate, bladder incontinence)	☐	☐	☐	☐	☐
10. **Dryness of vagina** (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)	☐	☐	☐	☐	☐
11. **Joint and muscular discomfort** (pain in the joints, rheumatoid complaints)	☐	☐	☐	☐	☐

Please share any additional comments about your symptoms you would like to address.

Do you have cold hands and feet? ☐ Yes ☐ No **Do you have daily bowel movements?** ☐ Yes ☐ No

Do you have gas, bloating or abdominal pain after eating? ☐ Yes ☐ No

Please select your WEEKLY Activity Level based on this criteria ➔ *Physical activity that accelerates heart rate / Breathlessness*

☐ 0-1 day per week (Low) ☐ 2-3 days per week (Average) ☐ More than 3 days per week (High)

Please list any prior hormone therapy?

FOR OFFICE USE ONLY

Today's Date:_____ _____ _

Rev 062019

Cosmetic Interest Questionnaire

What are your areas of concern? (Please check all that apply)

□ Frown Lines between brows

□ Significant lines around nose and mouth

□ Tired-looking skin

□ Facial Hair

□ Acne

□ Freckles

□ Fine lines and wrinkles

□ Rough skin texture

□ Sagging skin

□ Hyper-pigmentation

□ Dark circles under eyes

□ Dry skin

When looking at my face in the mirror

I believe I look younger than, the same as,

or older than my true age.

Younger Than True Age Older Than

1 2 3 4 5

When looking at my face in the mirror,

I am not concerned, somewhat concerned,

or very concerned about the appearance

of my wrinkles.

Not Concerned 1 | Somewhat Concerned 2 3 4 | Very Concerned 5

Recommendations

Skin Analysis & Skincare

(Office use only)

1._____

2._____

3._____

4._____

5._____

6._____

7._____

Are you interested in learning more about the following

□ Injectables

□ Facials

□ Chemical Peels

□ Sun Protection

□ Acne Topical treatment and creams

□ Spider vein removal

□ Laser Treatments

□ Alpha Hydroxy acid and glycolic peels

□ Skincare products

□ Skin rejuvenation

□ Age Spots/ Liver Spots

□ Facial vein removal

□ Hair removal / waxing

□ Body Contouring

_____ _____

Your Name (Please Print) Contact Phone (Home or Cell)