MALE PATIENT QUESTIONNAIRE

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

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: _____) ☐ Event (_____)
☐ Practitioner (Name: _____) ☐ Pharmacy (Name: _____)
☐ Social Media (Type: _____) ☐ TV (Station: _____) ☐ Radio (Station: _____)
☐ Web (Keyword Searched: _____) ☐ Signage (_____) ☐ Print (Ad seen in: _____)

In Case of Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Pharmacy Name: _____ Phone: _____

Address: _____

Primary Care Physician's Name: _____ Phone: _____

Address: _____

May we share your clinical information with your PCP? ☐ Yes ☐ No

MEDICAL HISTORY

Weight: _____ Have you ever had any issues with anesthesia? ( ) Yes ( ) No

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

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? _____

Current Medications and dosage: _____

_____

_____

Nutritional/Vitamin Supplements: _____

Current Hormone Replacement Therapy: _____ Past HRT: _____

Surgeries, list all and when: _____

Other Pertinent Information: _____

Do you have a family history of? ( ) Heart Disease ( ) Cancer ( ) Diabetes ( ) Other _____

Do you have a personal history of? Check all that apply.

( ) High blood pressure
( ) High cholesterol
( ) Heart disease
( ) Stroke
( ) Heart attack
( ) Blood clot or pulmonary emboli
( ) Hemochromatosis
( ) Depression / anxiety
( ) Psychiatric disorder
( ) Diabetes
( ) Thyroid disease
( ) Arthritis
( ) Trouble passing urine or take Flomax or Avodart
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis)
( ) Prostate enlargement
( ) Elevated PSA
( ) Cancer:
( ) Testicular or prostate Year: _____
( ) Other: _____ Year: _____

I understand that if I begin testosterone replacement with any testosterone treatment, including testosterone pellets, I will produce less testosterone from my testicles. And if I stop testosterone replacement I may experience a temporary decrease in my testosterone production. Testosterone pellets should be completely out of your system in 12 months.

PRINT NAME _____ SIGNATURE _____ DATE _____

Name: _____

D.O.B _____

Maricopa Wellness Center Med Spa

Maricopa Wellness Center
AMS Checklist- Before BHRT

Which of the following symptoms apply at this time?

Place an "X" for EACH symptom. For symptoms that do not apply, please mark NONE.

	None	Mild	Moderate	Severe	Extremely Severe
1. Decline in your feeling of general well-being (general state of health, subjective feeling)	☐	☐	☐	☐	☐
2. Joint pain and muscular ache (lower back pain, joint pain, pain in a limb, general back ache)	☐	☐	☐	☐	☐
3. Excessive Sweating (unexpected/sudden episodes of sweating, hot flushes independent of strain)	☐	☐	☐	☐	☐
4. Sleep Problems (difficulty in falling asleep, difficulty in sleeping through, waking up early and feeling tired, poor sleep, sleeplessness	☐	☐	☐	☐	☐
5. Increased need for sleep, often feeling tired	☐	☐	☐	☐	☐
6. Irritability (feeling aggressive, easily upset about little things, moody)	☐	☐	☐	☐	☐
7. Nervousness (inner tension, restlessness, feeling fidgety)	☐	☐	☐	☐	☐
8. Anxiety (feeling panicky)	☐	☐	☐	☐	☐
9. Physical exhaustion / lacking vitality (general decrease in performance, reduced activity, lacking interest in leisure activities, feeling of getting less done, of achieving less, of having to force oneself to undertake activities.	☐	☐	☐	☐	☐
10. Decrease in muscular strength (feeling of weakness)	☐	☐	☐	☐	☐
11. Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings, feeling nothing is of any use)	☐	☐	☐	☐	☐
12. Feeling that you have passed your peak	☐	☐	☐	☐	☐
13. Feeling burnt out, having hit rock-bottom	☐	☐	☐	☐	☐
14. Decrease in beard growth	☐	☐	☐	☐	☐
15. Decrease in ability / frequency to perform sexually	☐	☐	☐	☐	☐
16. Decrease in the number of morning erections.	☐	☐	☐	☐	☐
17. Decrease in sexual desire / libido (lacking pleasure in sex, lacking desire for sexual intercourse)	☐	☐	☐	☐	☐

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

_____

_____

Please list any prior hormone therapy?

_____

_____

Recent PSA: _____ Recent Digital Rectal Exam (Date): _____ Normal / Abnormal

History of Prostate problems or Biopsy. If so, please provide details.

_____

_____

Date:

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 do not accept insurance. _____ **Initials**
We will send a copy of your insurance card and photo ID to the lab so the lab can bill your insurance. You have the choice to file with your insurance and pay our cost. If you choose to file with your insurance for lab work, **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 service 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 medications require 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 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 48-hours prior to cancel your appointment.

I understand if I **no show or cancel** an appointment without notifying **Maricopa Wellness Center** within **48 hours prior to my appointment**, I will be charged a $50 non-refundable cancelation 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**

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:_____

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
41600 W Smith Enke Rd Bldg 14 STE 3
Maricopa AZ 85138
Tele: 520-464-6193

Informed Consent:

COVID-19

I, _____ understand that I am consenting to an elective treatment/procedure/ that is not urgent or emergent and may not be medically necessary.

I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact, and as a result, federal and state health agencies recommend social distancing. I understand that my practitioner and all staff at Maricopa Wellness Center has put in place reasonable safety measures to help reduce the spread of COVID-19.

I understand that even if I have received a negative COVID-19 test result, the test may have failed to detect the virus, or I may have become infected after I took the test. I understand that even if I do not have any symptoms, I may have a COVID-19 infection, and that having the elective treatment/procedure/ can lead to a higher chance of complication and death.

I understand that exposure to COVID-19 before, during, and after my treatment/procedure/ may result in the following: a positive COVID-19 diagnosis, extended isolation, additional tests, and hospitalization, up to and including: the need for treatment in intensive care (ICU), short-term or long-term intubation, other complications, and death. After my elective surgery I may need additional care that may require that I go to an emergency department or hospital.

I understand that COVID-19 may cause additional risks, some of which may not be known at this time.

I understand that this elective procedure may put me at increased risk for becoming infected with COVID-19. By signing this consent form I accept that risk and give my permission to proceed with the treatment/procedure/ listed below.

I have been given the choice to have my treatment/procedure at a later date. I understand the potential risks of delaying and want to proceed.

I have read this consent, or someone has read it to me.

Treatment/procedure: Services

Pt Name: _____ Date: _____

Pt Signature: _____