

Park NP Clinic Registration Form

Date _____

Patient information:

First name _____ Last name _____ MI _____

Preferred name _____ male/female _____

Date of Birth _____ Age _____

Address _____

City _____ State _____ ZIP _____

Preferred phone _____

Email address _____

Marital Status (circle) Single Married Widowed Divorced Separated Committed

Patient Employment Status: Employed Y/N _____ Student Y/N _____

Occupation _____

Referred By _____

Emergency Contact:

Relative/Friend _____ Phone _____

Relationship _____

Pharmacy Information:

Pharmacy Name _____

Phone _____

May we contact you regarding your protected health information?

Email: Y/N _____

Cell phone: Y/N _____

Leave Voicemail: Y/N _____

Name of Primary Care Provider _____ Last visit _____

Please list another specialists you see _____

Please provide a list of your current medications:

MEDICATION	DOSE	FREQUENCY	PRESCRIBING PROVIDER

Please provide a list of current supplements:

SUPPLEMENT	DOSE	YEARS OF USE	SOURCE

Please list any drug allergies:

Medication	Reaction

Park NP Clinic does not accept insurance. You may use your insurance for any testing ordered. If your insurance does not cover certain tests, a cash pay price may be more affordable with particular vendors.

Pricing of visits:

New patient appointments \$250 (40 mins)

Follow up visits are \$200 (30 mins)

Monthly check-ins are highly recommended during your weight loss phase. Those visits are \$100. Once you have entered weight maintenance, we can discuss a customized follow up plan for you with follow up visits every 3 months (\$200). Payments are due at the time of service. While the clinic does accept FSA/HSA and credit cards, a processing fee of 3.5% will be added to the total. You can avoid those fees by using Zelle to phone number 615-557-7585.

Telehealth Consent:

I authorize Julie Park, APRN to use a HIPAA compliant telehealth practice platform for consultations, evaluation, order testing, and diagnosing my medical condition.

I understand that technical difficulties may occur before or during my telehealth sessions and my appointment cannot be started or ended as intended.

I accept, if technical requirements cannot be met, my visit can be conducted via a regular phone communication.

I understand if a telehealth visit is appropriately indicated, that visit will be charged like an in-person office visit. Payment will be due at the time of service.

I agree that my medical records can be kept for further evaluation, analysis, and documentation. My information will be kept private in all of these circumstances.

Park NP Clinic is not an urgent care facility. It is a sole provider practice and by appointment only. If you have a medical issue that requires immediate attention, please proceed to the nearest emergency room or urgent care center. If you need to make an appointment or request a refill, you may call or text the office at 615-557-7585 or email Julie directly at Julie@parknpclinic.com.

I have received a copy of the Notice of Privacy Practices _____

Signature_____

Mens Health Intake Form

Name _____ Date _____

DOB _____

What is your reason for seeking care? _____

Have you ever been diagnosed with any health problems? If so, please list

Have you completed your family? Y/N _____

Do you wake up feeling rested in the morning? Y/N _____

Have you every had a sleep study? Y/N _____

Were you ever diagnosed with sleep apnea? Y/N _____

Have you ever had an issue with your prostate?

____ enlarged

____ cancer

____ elevated PSA

____ Difficulty urinating

Have you ever been evaluated by a urologist? Y/N _____ Last exam _____

Have you ever taken testosterone therapy? Y/N _____ currently taking? Y/N _____

Please indicate if you are experiencing any of the following symptoms:

SYMPTOMS	NONE	MILD	MODERATE	SEVERE	VERY SEVERE
Physical exhaustion (fatigue, lack of energy, stamina, motivation)					
Sleep problems (Difficulty falling asleep or sleeping through the night)					
Irritability (mood swings, feeling aggressive, angers easily)					
Anxiety (feeling overwhelmed, panicky, or nervous)					
Decline in drive or interest (lost in “zest for life”, feeling down or sad)					
Joint or muscular symptoms (poor recovery after workout, inability to add muscle, joint pain, muscle weakness)					
Difficulties with memory (concentration, finding the right word, or retaining information)					
Sexual desire or performance (reduced or diminished)					
Erectile changes (weaker erections, loss of morning erections)					
Ejaculations (infrequent or absent)					
Sweating (night sweats or increased episodes of sweating)					
Hair Loss, rapid or thinning					
Feeling cold all the time, having cold hands and feet					
Headaches or migraines (increased in frequency or intensity)					
Weight (difficulty losing weight despite diet/exercise)					
Bladder problems (difficulty urinating, increased need to urinate)					

Any other considerations: _____

NOTICE OF PRIVACY PRACTICES

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.

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

1. **Uses And Disclosures We May Make Without Written Authorization.** We may use or disclose your health information for certain purposes without your written authorization, including the following: **Treatment.** We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer. **Payment.** We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain payment for treatment. **Healthcare Operations.** We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice. **Other Uses or Disclosures.** We may also use or disclose your information for certain other purposes allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following: • To avoid a serious threat to your health or safety or the health or safety of others. • As required by state or federal law such as reporting abuse, neglect or certain other events. • As allowed by workers compensation laws for use in workers compensation proceedings. • For certain public health activities such as reporting certain diseases. • For certain public health oversight activities such as audits, investigations, or licensure actions. • In response to a court order, warrant or subpoena in judicial or administrative proceedings. • For certain specialized government functions such as the military or correctional institutions. • For research purposes if certain conditions are satisfied. • In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes. • To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

2. **Disclosures We May Make Unless You Object.** Unless you instruct us otherwise, we may disclose your information as described below. • To a member of your family, relative, friend, or other person who is involved in your healthcare or payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment. **NOTICE OF PRIVACY PRACTICES - 2**

3. **Uses and Disclosures With Your Written Authorization.** Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

4. **Your Rights Concerning Your Protected Health Information.** You have the following rights concerning your health information. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below. • You may request additional restrictions on the use or disclosure of information for treatment, payment or healthcare operations. We are not required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer. • We normally contact you by telephone, mail at your home address and possibly by e-mail if you have given your e-mail address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests. • You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We may

charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others. • You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record or if we determine that the record is accurate and complete. • You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period. • You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

5. **Changes To This Notice.** We reserve the right to change the terms of this Notice at anytime, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices,

we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from our receptionist or Privacy Officer.

6. Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying julie@parknpclinic.com. All complaints must be in writing. We will not retaliate against you for filing a complaint.