SILVER CREEK FAMILY PRACTICE, PLLC

Morganton, NC 28655

# Male Health History & Symptoms

Patient Questionnaire

**PATIENT NAME** | **DATE** | **DATE OF BIRTH**

**AGE** | **WEIGHT** | **HEIGHT**

## PATIENT QUESTIONS

| | | |
|---|---|---|
| Currently trying to conceive? | ☐ Yes | ☐ No |
| Desire to conceive in the future? | ☐ Yes | ☐ No |
| Taking a 5-alpha reductase inhibitor? | ☐ Yes | ☐ No |
| Taking a PDE-5 inhibitor (Cialis, Viagra, etc.)? | ☐ Yes | ☐ No |
| Taking another testosterone-boosting medication (Clomid, HCG, etc.)? | ☐ Yes | ☐ No |
| Currently using BHRT or HRT? | ☐ Yes | ☐ No |
| Currently taking a statin? | ☐ Yes | ☐ No |
| Current smoker? | ☐ Yes | ☐ No |
| Currently taking oral nitrates? | ☐ Yes | ☐ No |

**IF USING BHRT/HRT, LIST HORMONE(S) AND DOSE:**

## MEDICAL HISTORY - SELECT ALL THAT APPLY

**FERTILITY**

- ☐ Wants to maintain fertility
- ☐ Infertility treatment

**CARDIOVASCULAR**

- ☐ Heart attack or stroke (within 6 months)
- ☐ DVT/blood clot (within 6 months)
- ☐ Hypertension
- ☐ Hyperlipidemia
- ☐ Obstructive sleep apnea
- ☐ Anticoagulant medication
- ☐ Atrial fibrillation
- ☐ Tachycardia

**CANCER**

- ☐ Breast cancer
- ☐ Active/history of prostate cancer
- ☐ Thyroid cancer/history of thyroid cancer
- ☐ Meningioma
- ☐ Polycythemia vera
- ☐ Other cancer (except basal cell)

**NEUROLOGICAL CONDITIONS**

- ☐ Epilepsy/seizure disorder

**ENDOCRINE & METABOLIC**

- ☐ Type 2 diabetes/insulin resistance
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ MEN-2

# Male Health History & Symptoms



**PATIENT NAME**

**DATE OF BIRTH**

## ADDITIONAL MEDICAL HISTORY - SELECT ALL THAT APPLY

### AUTOIMMUNE CONDITIONS

- [ ] Type 1 diabetes
- [ ] Hashimoto thyroiditis
- [ ] Graves disease
- [ ] Rheumatoid arthritis
- [ ] Multiple sclerosis
- [ ] Systemic lupus erythematosus
- [ ] Psoriasis
- [ ] Positive ANA
- [ ] IBS (irritable bowel syndrome)
- [ ] Crohn disease
- [ ] Ulcerative colitis

### ORGAN-SPECIFIC CONDITIONS

- [ ] Liver disease/history
- [ ] Kidney disease/history
- [ ] LAM (lymphangioleiomyomatosis)
- [ ] Osteoporosis/osteopenia
- [ ] Prostate enlargement (BPH)
- [ ] HIV
- [ ] Hepatitis
- [ ] Hemochromatosis
- [ ] Pancreatitis/history
- [ ] Gallbladder disease/history

## SYMPTOMS & CONCERNS - SELECT ALL THAT APPLY

- [ ] Acne
- [ ] Erectile dysfunction (ED)
- [ ] Decreased libido
- [ ] Decreased desire
- [ ] Unable to or delayed orgasm
- [ ] Weight gain
- [ ] Decreased muscle mass
- [ ] Difficulty sleeping
- [ ] Urinary incontinence
- [ ] Dry/flaking skin
- [ ] Lack of energy (fatigue)
- [ ] Decreased strength/endurance
- [ ] Decreased work performance
- [ ] Frequent urinary tract infections
- [ ] Brittle nails
- [ ] Thinning eyebrows
- [ ] Hair thinning
- [ ] Cold hands/feet
- [ ] Mind racing at bedtime
- [ ] Mood swings
- [ ] Gynecomastia
- [ ] Abdominal obesity

## OTHER CONDITIONS, SYMPTOMS, OR CONCERNS

# Hormone Replacement

Fee Acknowledgment & Insurance Disclaimer

**PATIENT NAME**

**DATE OF BIRTH**

Preventive medicine and bioidentical hormone replacement are considered alternative or elective medicine. Although our clinicians are licensed and board-certified, many insurance plans do not cover bioidentical hormone replacement services.

Payment is due at the time of service. Upon request, we can provide a receipt and supporting form for you to submit to your insurance company. Silver Creek Family Practice will not contact, pre-certify, appeal, or otherwise communicate with your insurance company regarding these services. Any reimbursement request is the patient's responsibility.

Patients may use an eligible Health Savings Account (HSA) or other accepted payment method. Some plans require payment in full followed by a reimbursement request. It is your responsibility to request and submit any necessary receipt or paperwork.

## CURRENT FEES

| | |
|---|---|
| **New Patient Office Visit Fee** | **No charge** |
| **Male Hormone Pellet Insertion Fee** | **$735** |

## ACCEPTED PAYMENT METHODS

Cash, Visa, debit card, Mastercard, American Express, HSA, and CareCredit.

## ACKNOWLEDGMENT

By signing below, I confirm that I have read and understand this fee acknowledgment and insurance disclaimer. I accept financial responsibility for services provided.

**PRINTED NAME**

**DATE**

**SIGNATURE**

# HIPAA Information & Consent

Patient-Friendly Summary

**PATIENT NAME**

**DATE OF BIRTH**

The Health Insurance Portability and Accountability Act (HIPAA) protects the privacy of your protected health information (PHI). This summary explains how our office handles your information. A complete Notice of Privacy Practices is available from our office.

## OUR PRIVACY PRACTICES

1. We keep patient information confidential and use or share it as needed for treatment, payment, and health care operations, including with other providers, laboratories, and insurance payers.
2. We may contact you about appointments or office updates by telephone, text, email, or mail, according to your preferences and applicable law.
3. Vendors that may access PHI must agree to follow HIPAA confidentiality requirements.
4. Government agencies or insurance payers may inspect records when legally authorized and performing their duties.
5. Please bring privacy concerns or complaints to the office manager or your clinician.
6. We will not use your confidential information for marketing or advertising without appropriate authorization.
7. You may access your records as allowed by state and federal law.
8. You may request restrictions or changes in how we use or disclose PHI. We will consider requests but may not be required to agree, except where the law requires it.
9. Our privacy policies may be updated as permitted by law. The current notice will be available from the practice.

## CONSENT

I acknowledge that I received or had access to this HIPAA information and consent to the practices described above. I understand that this consent remains in effect unless changed or revoked as permitted by law.

**PRINTED NAME**

**DATE**

**SIGNATURE**

# Request to Restrict Disclosure to Health Plan

HITECH Act Section 13405(a)

**PATIENT NAME**

**DATE OF BIRTH**

I request that Silver Creek Family Practice not disclose protected health information (PHI) about the services/items listed below to my health plan or other third-party insurance carrier for payment or health care operations. I understand this request applies only when the service/item is paid in full out of pocket, unless disclosure is required by law.

I understand that the restricted service/item will not be billed to my health plan. I accept personal financial responsibility and agree to pay the finalized charge in full at the time of service.

## REQUESTED RESTRICTION

**TOTAL OR ESTIMATED CHARGE**

$735 per treatment

## PATIENT ACKNOWLEDGMENT

I understand that I am personally responsible for the full finalized charge for the restricted services/items.

**PRINTED NAME**

**DATE**

**SIGNATURE**

## PRACTICE USE ONLY

**WITNESS PRINTED NAME**

**DATE**

**WITNESS SIGNATURE**