INVIGORATE

Men's & Women's Wellness Center | 2629 Plaza Parkway Suite 5A | Wichita FallsTexas76308 | 940.386.9334

FEMALE QUESTIONNAIRE & HISTORY

Patient Information

Name:		Date of Birth:
Age:	Weight:	Occupation:
Mailing Address/City/State/Zip Code:		
Cell Phone:	Home Phone:	Work Phone:
Preferred Contact: ☐ Cell ☐ Home ☐ Work		
Email Address:		May we contact via email? ☐ Yes ☐ No
Pharmacy Name & Address:		Phone Number:
Primary Care Physician Name & Address:		Phone Number:
OBGYN Physician Name & Address:		Phone Number:
May we share your clinical information with your PCP/OBGYN? ☐ Yes ☐ No		
In case of emergency contact:		Relationship:
Cell Phone:	Home Phone:	Work Phone:
Marital Status: ☐ Married ☐ Divorced ☐ Widow ☐ Living with Partner ☐ Single		
In the event we cannot contact you by the means you've provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment? ☐ Yes ☐ No If yes, please provide:		
Name:	Relationship:	Phone #:
How did you hear about us? ☐ Social Media ☐ Web ☐ Tv ☐ Practitioner ☐ Patient		Name of Practitioner/Patient:

Signature: _____ Date: _____

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Social:	**Habits:**
☐ I am sexually active. ☐ I want to be sexually active. ☐ I have completed my family. ☐ My sex has suffered. ☐ I haven't been able to have an orgasm.	☐ I smoke cigarettes or cigars ____ per day. ☐ I drink alcoholic beverages ____ per week. ☐ I drink more than 10 alcoholic beverages a week. ☐ I use caffeine ____ a day.

Medical History

Any known drug allergies & reaction:

Have you ever had any issues with local anesthesia? ☐ Yes ☐ No If yes, please explain:

Medications currently taking:

Current hormone replacement therapy? ☐ Yes ☐ No If yes, please explain:

Past hormone replacement therapy? ☐ Yes ☐ No If yes, please explain

Nutritional/Vitamin Supplements:

Surgeries, list all & When:

Last menstrual period (estimate year if unknown):

Other pertinent information:

Preventative medical care:	**High risk past medical/surgical History:**	**Birth control method:**
☐ 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	☐ Breast cancer ☐ Uterine Cancer ☐ Ovarian cancer ☐ Hysterectomy with removal of ovaries ☐ Hysterectomy only ☐ Oophorectomy removal of ovaries	☐ Menopause ☐ Hysterectomy ☐ Tubal ligation ☐ Birth control pills ☐ Vasectomy ☐ IUD ☐ Other ____

Medical Illnesses:

☐ Polycystic ovary syndrome (PCOS)	☐ Blood clot and/or a pulmonary embolism	☐ Diabetes
☐ High blood pressure	☐ Arrhythmia	☐ Thyroid disease
☐ Heart bypass	☐ Any form of hepatitis or HIV	☐ Arthritis
☐ High cholesterol	☐ Lupus or other auto immune disease	☐ Depression/anxiety
☐ Hypertension	☐ Fibromyalgia	☐ Psychiatric disorder
☐ Heart disease	☐ Trouble passing urine or take Flomax or Avodart	
☐ Stroke and/or heart attack	☐ Chronic liver disease (hepatitis, fatty liver, cirrhosis)	

☐ Cancer (type & year): _____

Signature: _____ Date: _____

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Health Assessment for Women

Which of the following symptoms apply currently?
Place a ☑ for each symptom. For symptoms that do not apply, please mark none.

	None	Mild	Moderate	Severe	Extremely Severe
Hot flashes, Night sweats (episodes of sweating)	☐	☐	☐	☐	☐
Sleep Problems difficulty in falling asleep; sleeping through the night; waking up early)	☐	☐	☐	☐	☐
Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings)	☐	☐	☐	☐	☐
Irritability (feeling nervous, inner tension, feeling aggressive)	☐	☐	☐	☐	☐
Anxiety (inner restlessness, felling panicky)	☐	☐	☐	☐	☐
Physical/Mental exhaustion (general decrease in performance; impaired memory; concentration; forgetfulness)	☐	☐	☐	☐	☐
Sexual problems (change in sexual desire; sexual activity; satisfaction)	☐	☐	☐	☐	☐
Bladder problems (difficulty in urinating, increase need to urinate, bladder incontinence)	☐	☐	☐	☐	☐
Dryness of vagina (sensation of dryness or burning in the vagina; difficulty with sexual intercourse)	☐	☐	☐	☐	☐
Joint/muscular discomfort (pain in the joints; rheumatoid complaints)	☐	☐	☐	☐	☐

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

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Super B12 Slim Boost Consent

The Super B12 Slim Boost is a vitamin-packed injection that can help boost energy, promote good health, and speed up metabolism in patients. A careful blend of vitamins and essential nutrients can jumpstart your weight loss process while strengthening your overall health; contains Vitamin b12, Vitamin C, Vitamin B1, Vitamin b3, Inositol, Choline, Methionine, Riboflavin (B2) and Vitamin B5.

- Energy boost
- Increased metabolism
- Supported well-being and mood.
- Improved metabolism of carbohydrates and fats
- Eliminates toxins.
- Improved brain function and memory
- Repair damaged tissue and wound healing
- Speed weight loss
- Lowers cholesterol.
- Support for organs such as heart, pancreas, kidney, and liver

$25 for 1 Injection or $150 for 10 Injections

I understand the ingredients and actions of the Super B12 Slim Boost and verify that I have been instructed on the possible complication of IM injections; include but are not limited to injury to blood vessels, bruising and/or swelling at the injection site, swelling scar tissue formation, tenderness and/or pain at the injection site, cellulitis (injection), and tissue necrosis. In the event of any complications, I will immediately contact the staff at Invigorate Men's & Women's Wellness Center.

Name: _____ Signature: _____ Date: _____

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Off-Label Thyroid Consent Form

Off-Label Medication Information
Medication: Desiccated Thyroid Extract
FDA Approved Use: Hypothyroidism, Thyroid Cancer
Off-Label Use: _____

Desiccated thyroid extract (Armour Thyroid, NP Thyroid, WP Thyroid, Westhroid, NatureThroid) is an extract of thyroid hormone that comes from pigs. It is FDA approved for use in hypothyroidism and in some types of thyroid cancer. The off-label uses have not been evaluated by the FDA and any claims of benefit are purely educated opinions that come from consideration of various medical research studies.

The American Academy of Clinical Endocrinology guidelines do not provide for the use of this medication for anything other than hypothyroidism. For any approved use of this medication, the AACE guidelines also state that the preferred medication is levothyroxine (Synthroid).

Thyroid hormone, in medical research, has been shown to improve fatigue, fibromyalgia, cholesterol, glucose, metabolism, hair loss, weight, and other conditions. It has been used to treat infertility also. The proposed mechanism of improvement of fertility is through treatment of a condition called polycystic ovarian syndrome (PCOS).

Thyroid hormones, in excessive doses can cause elevated blood pressure, anxiety, heart racing, irregular heartbeat, excessive weight loss, and, in very extreme cases, prominence of the eyes (exophthalmos). Thyroid hormone, taken by people who have a normally functioning thyroid gland, for extended periods of time, can cause normal thyroid function to decline, necessitating lifelong treatment with this medication.

AACE guidelines define hypothyroidism as TSH (lab test, thyroid stimulating hormone) greater than 4. In some cases, TSH greater than 2.5 can be hypothyroidism. If your TSH isn't above these ranges, then you do NOT have a diagnosis of hypothyroidism. There are other thyroid tests that can be considered. These tests, while helpful in making a treatment decision, are not considered to be the standard.

Once treatment with this medication is begun, you are asked to please call the office with any concerns. If you have any adverse reaction to this medication, stop it and call immediately.

Frequent adjustments are required to fine tune the treatment with this type of medication. Periodic blood tests are necessary to determine if the dose needs to be adjusted.

Goals for treatment with medication will be discussed at each lab results appointment. If goals are met, then maintenances doses will be discussed. If the treatment is not as effective as anticipated, it might be discontinued. At that time, alternative therapies will be discussed.

You are welcome to seek a second opinion or a specialist consultation. As stated above, understand that other physicians, even specialists, might not agree with or understand the goal of this type of treatment.

I have read and agree with the above. My questions have been answered and I understand the treatment and goals.
I hereby release and agree to hold harmless Invigorate Men's & Women's Wellness Center and any of their physicians, nurses, officers, directors, employees, and agents from all liability, claims, demands, and actions arising or related to any loss, property damage, illness, injury, or accident.

I acknowledge and agree that I have been given an adequate opportunity to review this document and to ask questions. This release and hold harmless agreement is and shall be binding on myself and my heirs, assigns and personal representatives.

Name: _____ Signature: _____ Date: _____

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HIPAA INFORMATION & CONSENT

The health Insurance Portability and Accountability Act (HIPPA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 12, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

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. HIPAA 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. Patient 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, laboratories, health insurance payers as is 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 to people other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other document information.
2. It is the policy of this office to remind patients of their appointment, we may do this by telephone, email, US mail, or by 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 that you might find valuable or informative.
3. The practice utilizes several vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and a review of documents which may include PHI by government agencies or insurance payers 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 provider.
6. Your confidential information will not be used for the purposes of marketing or advertising products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions on the use of your protected health information and to request a change in certain policies used by the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPPA information form and any subsequent changes in office policies. I understand that this consent shall remain in force from this time forward.

Name: _____ Signature: _____ Date: _____

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed. Please Review it carefully.

Invigorate Men's & Women's Wellness Center 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 have created 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, authorized trainees, or by your personal doctor. This tells you about the ways in which Invigorate Men's & Women's Wellness Center may use and disclose health information about you. We also describe your rights to health information 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.

Invigorate Men's & Women's Wellness Centers provider, staff and other health 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.

Invigorate Men's & Women's Wellness Center 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. 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.

Invigorate Men's & Women's Wellness Center 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.

We may use and disclose health information to contact to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you as well as sending appointment reminders via text message.

I have reviewed the privacy practice notice for Invigorate Men's & Women's Wellness Center and understand the situation in which this practice may need to utilize and/or release my medical records.

Name: _____ Signature: _____ Date: _____

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Hormone Replacement Fee Acknowledgement

Although more insurance companies are reimbursing patients for Hormone Replacement Therapy, **there is no guarantee.** You will be responsible for payment in full at the time of your procedure. We will give you a receipt to send to your insurance company to file for reimbursement upon request.

New Patient Consult Fee with Labs $300

Female Hormone Pellet Insertion Fee: $350

WE DO NOT FILE INSURANCE ON THIS PROCEDURE – IT IS OUT OF NETWORK

We accept the following form of payment:

Mastercard, Visa, Discover, Personal Checks and Cash

Insurance Disclaimer

Preventative medicine and bio-identical hormone replacement is a unique practice and is considered a form of alternative medicine. Even though the physicians and nurses are board certified as Medical Doctors and RN'S OR NP'S, insurance does not recognize it as necessary medicine but is considered like plastic surgery (esthetic medicine) and therefore is not covered by health insurance in most cases.

Invigorate Men's & Women's Wellness Center is not associated with any insurance companies, which means they are not obligated to pay for our services (blood work, consultations, insertions, or pellets). We require payment at the time of service and, if you choose, we will provide you with a receipt showing that you paid out of pocket. WE WILL NOT, however, communicate in any way with insurance companies.

The form and receipt are your responsibility and serve as evidence of your treatment. We will not call, write, pre-certify, or make any contact with your insurance company. Any follow-up letters from your insurance to us will be thrown away. If we receive a check from your insurance company, we will not cash it, but instead return it to the sender. Likewise, we will not mail it to you. We will not respond to any letters or calls from your insurance company.

For Patients who have access to a Health Savings Account, you may for your treatment with credit or debit card. This is the best idea for those patients who have an HAS as an option in their medical coverage.

Name: _____ Signature: _____ Date: _____