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

MALE 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:
May we share your clinical information with your PCP/Urologist? ☐ 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:

Other pertinent information:

Medical Illnesses:

☐ High blood pressure	☐ Arthritis
☐ High cholesterol	☐ Stroke and/or heart attack
☐ Hypertension	☐ Elevated PSA
☐ Heart disease	☐ Prostate enlargement
☐ Arrhythmia	☐ Depression/Anxiety
☐ Diabetes	☐ Blood clot and/or a pulmonary embolism
☐ Fibromyalgia	☐ Lupus or other auto immune disease
☐ Thyroid disease	☐ Trouble passing urine or taking Flomax or Avodart

☐ Cancer (type & year): _____

☐ Other: _____

Signature: _____ Date: _____

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Health Assessment for Men

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
Decline in your feeling of general well-being (General state of health, subjective feeling)	☐	☐	☐	☐	☐
Body Aches (lower back pain, joint pain, pain in a limb, general back ache)	☐	☐	☐	☐	☐
Excessive Sweating (unexpected/sudden episodes of sweating, night sweats)	☐	☐	☐	☐	☐
Sleep Problems (difficulty in falling asleep, sleeping through the night or waking up too ealry and feeling tired)	☐	☐	☐	☐	☐
Increased need for sleep (often feeling tired)	☐	☐	☐	☐	☐
Irritability (mood swings, feeling aggressive, angers easily)	☐	☐	☐	☐	☐
Anxiety (inner restlessness, feeling panicky, feeling nervous, inner tension)	☐	☐	☐	☐	☐
Physical Exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina, or motivation	☐	☐	☐	☐	☐
Joint or Muscular Symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)	☐	☐	☐	☐	☐
Depressive Mood (feeling down, sad, lack of drive)	☐	☐	☐	☐	☐
Feeling that you have passed your peak (feeling burnt out, having hit rock bottom)	☐	☐	☐	☐	☐
Increased fat around your mid-section	☐	☐	☐	☐	☐
Decrease in beard growth	☐	☐	☐	☐	☐
Sexual problems (change in sexual desire, sexual performance or lacking pleasure in sex)	☐	☐	☐	☐	☐
Erectile changes (less strong erections, loss/decrease of morning erections)	☐	☐	☐	☐	☐
Please share any other symptoms you would like to address:					

Name: _____ Date: _____

Consent to Have Blood Drawn for Treatment/Testing

I authorize the medical staff at Invigorate Men's & Women's Wellness Center to obtain blood samples for the purpose of determining if I am a candidate for testosterone replacement treatment. The lab testing will include testosterone level, PSA, CBC, CMP and Estradiol level which will all be sent out to LabCorp. Any additional laboratory testing may be ordered as determined by the provider. I am aware that a copy of my insurance information will be sent to LabCorp and if I have a deductible or lab co-pay it may apply to the lab and not invigorate.

Male Prostate Exam Wavier for Testosterone Replacement Therapy

I, _____ voluntarily choose to undergo testosterone replacement therapy. I have been informed of the risks. All men considering testosterone replacement therapy should undergo a thorough prostate cancer screening that would include a digital rectal exam within the first year of treatment, I understand the importance of the exam and elect to defer to my Primary Care Provider (PCP). If you do not have a PCP let us know and we will make an appointment for you with one or with a Urologist.

Consent for Receiving Treatment at Invigorate Men's & Women's Wellness Center

I, _____ discussed and agree as a patient that I will not receive treatment for testosterone or other hormone replacement therapy at another facility. I am aware by doing so I will cause harm to my health and acknowledge that I would be released as a patient if this occurs.

Consent for B12 Injections

Vitamin B12 helps maintain good health and has been shown to be beneficial in reducing stress, fatigue, improving memory and cardiovascular health and maintain a good body weight. It can assist the body in converting proteins, fats, and carbohydrates into energy as well as being necessary for healthy skin and eyes. B12 injections are absorbed by the body.

Common Side Effects of B12

- I understand there is a risk of mild diarrhea, upset stomach, nausea, feeling of pain, warm sensation at the site of injection, bloating, headaches, and joint pain. I understand if I have these symptoms and they become troublesome I will contact the staff at Invigorate Men's & Women's Wellness Center.

- I understand that B12 injections can result in serious side effects which are rare occurrence, but patients should be aware of the following: rapid heart rate, flushed face, muscle cramps or weakness, dizziness, hives, skin rashes, shortness of breath, wheezing or coughing.

- Before starting vitamin B12 injection I will make sure I have told the provider if I have any of the following conditions: kidney disease, liver disease, iron deficiency, folic acid deficiency, or an allergy to Cobalt or any other medication/vitamin, dye, food, or preservatives.

I acknowledge that I have read the following consent and agree to the treatment, and I hereby release the provider or medical staff member giving the injection at Invigorate Men's & Women's Wellness Center from liability with the procedure.

Signature: _____ Date: _____

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Patient Name: _____

Consent for Testosterone Replacement Treatment (TRT)

Testosterone replacement treatment (TRT) along with diet, exercise, and a healthy lifestyle can improve your health. Some of the benefits are improved libido, increased energy, improved mood, better sleep, decreased body fat, and the overall feeling of "feeling like yourself again".

Please initial each statement below

____1. **It has been explained to me that sometimes there are risk/side effects related to TRT. If any of the following develop you will notify the provider or staff at Invigorate Men's & Women's Wellness Center.**

____ 2. **Acne on chest or back**

____ 3. **Mood swings**

____ 4. **Extra fluid in hands or feet (may occur in patients with CHF, kidney, or liver disease)**

____ 5. **Decrease in sperm count which can lead to infertility.**

____ 6. **Breast enlargement (which is caused by adipose tissue NOT TRT), however you may experience breast tenderness or nodules.**

____ 7. **Testosterone is produced by the testes or testicles. Low testosterone will also cause the testicles to shrink, TRT will cause this as well. The more you are supplemented the less your own body will produce.**

____ 8. **Prostate enlargement is NOT caused by TRT, but an enlarged prostate can cause a change in urination, urinary stream, and frequency of urination.**

____ 9. **Changes in HCT, PSA, or Estradiol levels. All levels will be monitored with lab tests throughout treatment. Testosterone levels will be checked monthly or after 4 consecutive weeks of treatment.**

____ 10. **TRT may increase the risk of deep vein thrombosis (DVT), a blood clot in the calf. A DVT will make your calf, red, warm, swollen, and tender to touch. This is considered a medical emergency and needs to be treated at the nearest emergency room. If untreated, this blood clot could break off and go straight to the lungs causing pulmonary embolus which could result in respiratory distress and possible death.**

____11. **Increased red blood cell production is a benign condition called Erythrocytosis. If symptomatic it could result in periodic therapeutic phlebotomy to continue your treatment or stopping treatment as directed by the provider until levels are within normal limits. This does not make the blood thick. However, there is a rare bone marrow disease called Polycythemia Vera (PV). PV causes the bone marrow to produce to many red blood cells, white blood cells and platelets. PV is a rare disorder that occurs most often in men. It is not usually seen in people under the age of 40. The problem is often linked to gene defects, the cause of the gene defect is unknown and is not an inherited disorder.**

____ 12. **I understand that the benefits of therapy are not guaranteed and if I stop treatment my condition may return.**

____ 13. **I agree to have my primary care physician perform my yearly full physical exam to include a digital rectal exam. The exam I have at Invigorate Men's & Women's Wellness Center DOES NOT replace a full physical by my PCP.**

____ 14. **I have had the opportunity to discuss with the provider about my medical history, lab results, symptoms, medications, benefits, and risk/side effects of testosterone replacement treatment.**

I fully understand and I consent to having the provider and the MA's at Invigorate Men's & Women's Wellness Center begin Testosterone Replacement Treatment.

Patient Signature: _____ Date: _____

Provider/Staff 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: _____

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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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FINANCIAL AGREEMENT

Thank You for selecting Invigorate Men's & Women's Wellness Center as your healthcare provider. We are committed to providing you with the best possible care. If you have medical insurance, we strive to help you receive your maximum allowable benefits. To achieve these goals, we need your assistance and your understanding of our payment policy, which we require you to read and sign prior to any treatment.

Payment Methods- Payment is expected at the time services are rendered. We accept cash, money order, VISA, MasterCard. We will now be collecting your co-pays and deductibles (if applicable) upon your office visit, and you will be expected to pay your co-pay/co-insurance.

Insurance Information- We must emphasize that you are the insured party. Because your insurance policy is a contract between you and your insurance company, please check with your insurance carrier to determine any pre-existing limitations or other benefit restrictions that you may have, prior to your appointment. We will file your insurance as a courtesy and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim or not. To avoid any issues with this insurance policy, please provide us with the most up to date insurance information you have at each clinic visit.

Lab/Diagnostic Services- It is office policy that patients will be subject to lab tests at any/all office visits. You may receive a separate bill for these services. As the patient, you are financially responsible for any co-pay or balances due for these services if they are not reimbursed by your insurance for any reason.

Uninsured- Cash options available. Please discuss with the front desk coordinator in your clinic for details.

Private Insurance-Typically this type of plan pays a percentage of the contracted amount after the deductible has been met. Our business office will file your charges with your carrier. Any amount not paid by the carrier will be your responsibility to pay.

Contractual Agreements- (PPO's, HMO's), generally a co-pay is required at the time services are rendered. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. You are responsible for all non-covered services.

Insurance Changes- If there are any changes to your insurance coverage, please provide our office with that information within 24 hours of change. If you fail to provide us with correct information you will be responsible for the entire balance.

Returned Checks- A $35.00 cash fee will be charged for any returned checks. We will be unable to accept your checks for any future services.

We must emphasize that as your medical care provider, our relationship is with YOU, not your insurance company. Although we will file your charges with your insurance carrier, please keep in mind that you are deemed responsible for all charges not paid for or covered by your insurance company.

I have read, understand, and agree to this Financial Agreement

SIGNED: _____ DATE: _____

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Hormone Replacement Pellet 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:	**$750**

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: _____