Valdosta Health
& WELLNESS CLINIC
A NEW BEGINNING. NATURALLY

Phone: 229-469-6137 • Fax: 229-469-6139

Please read these forms carefully and answer all questions as accurately as possible.

Blood Work

*If you are an uninsured patient or have a high deductible please note that we have self-pay prices on labs to help with the cost of treatment.

*It is your responsibility to find out which lab company your insurance will cover. Labs can be drawn in the clinic at your visit, but you will be charged a $35.00 venipuncture fee that we do not bill to your insurance company. We use Quest diagnostics, so in the event your insurance does not contract with this lab company please let us know at your first visit.

*It is our goal to make our patients happy, and we are more than willing to work with you as much as possible to make that happen. We want just as much of the cost to be covered as you do. Knowing exactly what your insurance will and will not cover will keep you from receiving any unexpected costs.

*Follow up hormone and thyroid labs will need to be drawn in the morning as soon as possible. Thyroid meds will need to be taken that morning, and hormones the night before. This is when levels are most accurate. If you are on testosterone injections remember to hold off on the injection a week prior to having your level drawn.

Cancellations and No show policy

Once you call and schedule an appointment, that time is blocked off for you. During your appointment, you will be given the same amount of time in the room with the provider as every other patient. Since these appointments are set aside for you and only you, we ask that in the event you cannot make your appointment, please give us a 24-hour notice of cancellation. This ensures that time will not be wasted, and other patients can be seen.

Failure to provide a 24-hour notice of cancellation will result in a now show fee that will need to be settled before another appointment can be scheduled.

Female Hormone Assessment

3328 Bemiss Rd Valdosta, Ga 31605
(229) 469 6137

Patient Information **Date:** ____________________

Name ____

Birthdate ______________ **Social** ______________

Mobile Phone ________________________________

Home Phone _________________________________

Address _____________________________________

City ____________ **State** _________ **Zip** __________

Email _______________________________________

Sex (please circle): **Male** **Female**

Are you? (please circle below)

Married **Single** **Divorced** **Widowed** **Separated**

Occupation __________________________________

Work Phone __________________________________

Work Address ________________________________

City ____________ **State** __________ **Zip** _________

Emergency Contact Information:

Name ____

Relation to patient ___________________________

Phone # ______________________________________

Address _____________________________________

City _________________ **State** _______ **Zip** ________

Insurance Information:

Insurance Company ___________________________

Identification # ______________________________

Group # _____________________________________

Account Holder or Responsible Party:

Name ____________________ **Relation** ______________

Birthdate _____________ **Social** _____________________

Phone _______________________________________

Address _____________________________________

City ______________ **State** ________ **Zip** ____________

Secondary Insurance ________________________

Insurance Company ___________________________

ID # ____

Group # _____________________________________

Please Note

- If you are an uninsured patient, or have a high deductible we do offer self-pay prices with labs to help cover the cost of treatment.
- There is a $35 venipuncture fee that will need to be paid prior to having labs obtained in this facility. This fee is not charged to your insurance company.
- You will be charged a no show fee of $100.00, in the event you do not show up for your first scheduled appointment, and a $50.00 no show fee for any appointment missed after the initial visit. It is your responsibility to resolve any missed appointment fees before another appointment can be scheduled. Please give us a 24-hour notice if you need to reschedule.

Insurance Release

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the Practitioner at Valdosta Health & Wellness Clinic. I understand that I am financially responsible for any balance. I also authorize Valdosta Health & Wellness Clinic to bill the insurance company, and to release any information required to process my claim. I have also read the HIPPA privacy notice, and understand that a copy will be provided to me upon my request.

Patient Signature ______________________________ Date ______________________

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OB History

- How many times have you been pregnant? ________________________
- How many miscarriages have you had? ________________________
- How many abortions have you had? ________________________
- Have you had any tubal/ectopic pregnancies? ________________________
- How many Vaginal pregnancies have you had? ________________________
- How many Cesarean Sections have you had? ________________________
- Have you had any premature deliveries? ________________________
- How many full-term deliveries? ________________________
- Have you had any twin births? ________________________
- List any complication you have had with your pregnancies.

  ____

  ____

GYN History

- Are you sexually active? ( ) Yes ( ) No
- Have you been sexually active? ( ) Yes ( ) No
- Do you have pain with intercourse? ( ) Yes ( ) No
- What type of contraception are you currently using? (Circle below)

  Pills Condoms Tubal ligation Withdrawal Depo Provera IUD

  Foam Vasectomy Diaphragm Implants Other________________________
- Are you having any problems with your method of birth control? ( ) Yes ( ) No
- Have you ever had any vaginal, cervical, and/or tubal infection? ( ) Yes ( ) No
  - If yes, please circle below:

Yeast Gardnerella Syphllis Condyloma Bacterial Vaginitis PID Herpes Trichomonas

Chlamydia Gonorrhea Warts Other ________________________

- Date of last pap smear? ____________ Was it abnormal? ( ) Yes ( ) No
  - If yes, how was it treated? (Circle below)

Repeated pap Colposcopy laser surgery cone biopsy cryosurgery (freezing)

Hysterectomy Loop Excision Other ________________________

- Do you have any breast lumps, tenderness, or discharge? ( ) Yes ( ) No
- Have you had a mammogram? ( ) Yes ( ) No

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- If you have had a mammogram please list the date mammogram was preformed along with any abnormalities ____
____
- Do you do breast self-exams? ( ) Yes ( ) No
- Do you have any uterine abnormalities? ( ) Yes ( ) No
- Do you have a history of infertility? ( ) Yes ( ) No

Menstrual History

- If you no longer have periods, please state reason: ______________________
- First day of last period? ______________________
- How many days does your period normally last? ______________________
- How many days from the start of one period to the start of the next period? ______________
- Has the flow changed in any way? If so, how? ______________________
- Do you have any bleeding in between periods? ( ) Yes ( ) No
- Do you have any cramping with your periods? ( ) Yes ( ) No
  - If yes, are the cramps? ( ) Mild ( ) Moderate ( ) Severe
- List any medications you take for cramping? ______________________

Social History

- Do you smoke cigarettes? ( ) Yes ( ) No
  - If yes, how many packs per day? __________ Number of years? ______________
- Do you use street drugs? ( ) Yes ( ) No
- Do you drink alcohol? ( ) Yes ( ) No
  - If yes, how much per day/week/month? ______________________

Family History

- Do you have a family history of breast cancer? ( ) Yes ( ) No
  - If yes, whom? ______________________
- Do you have a family history of colon cancer? ( ) Yes ( ) No
  - If yes, whom? ______________________
- Do you have a family history of ovarian cancer? ( ) Yes ( ) No
  - If yes, whom? ______________________
- Do you have a family history of osteoporosis? ( ) Yes ( ) No
  - If yes, whom? ______________________
- Do you have a family history of diabetes? ( ) Yes ( ) No
  - If yes, whom? ______________________
- Do you have a family history of hypertension? ( ) Yes ( ) No
  - If yes, whom? ______________________
- Do you have a family history of heart disease? ( ) Yes ( ) No
  - If yes, whom? ______________________
- Do you have a family history of kidney disease? ( ) Yes ( ) No
  - If yes, whom? ______________________

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Sexual History

- Are you sexually active? ( ) Yes ( ) No
- Do you have a history of sexually transmitted diseases? ( ) Yes ( ) No
  - If yes, please describe: ______________________________
- Do you have a hard time reaching orgasm? ( ) Yes ( ) No
- Has your sex drive declined within the past five years? ( ) Yes ( ) No
- Are you HIV positive? ( ) Yes ( ) No
- Sexual orientation please circle: Heterosexual Homosexual Bisexual

Past Medical History

Do you have, or have you ever been treated for any of the following:

( ) Diabetes ( ) Hypertension ( ) Heart Disease ( ) Heart Murmur ( ) Kidney Disease

( ) Psychiatric Problems ( ) Rheumatic Fever ( ) Mitral Valve Prolapse ( ) Urinary Tract Infection

( ) Hepatitis/liver disease ( ) Varicosities/phlebitis ( ) Thyroid Problems (what type): ______________

( ) Asthma or lung disease ( ) Autoimmune disorder (what type): ______________________________

( ) Cancer (what type): ______________________

- Do you have any drug allergies?

  ____
  ____
  ____
  ____

- List all surgeries you have had in the past?

  ____
  ____
  ____
  ____
  ____

General Health & Lifestyle

- Overall General Health: ( ) Good ( ) Fair ( ) Poor
- Do you exercise? ( ) Yes ( ) No If yes, how often? ____________________
- Are you currently on any type of diet for weight loss? ( ) Yes ( ) No
  - If yes, what diet? ____
- Are you on any type of special diet (example would be gluten free)?

  ____

- Have you ever been diagnosed with any vitamin deficiencies (type)?

  ____

- Have you ever been diagnosed as iron deficient anemic? ( ) Yes ( ) No
- Have you ever suffered from an eating disorder (type)? ______________________________

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Current Medications

List all medications that you are currently taking, along with any vitamins or supplements.

Drug Name	Dosage	Frequency taken throughout day

Do you have a preferred pharmacy? ____

Do you have a preferred compounding pharmacy? ______________________________________

- Certain pharmacies that we use for compounding are out of state, and may need to ship a prescription to you. Keep in mind that certain medications may need to be refrigerated upon arrival. If shipping address differs from your billing address that we have on file, please specify shipping address below so that we can inform any out of state pharmacies.

Address ______________________________ City ______________ State_______ Zip _____

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Bio-Identical Hormone Therapy Assessment

Rate the following symptoms by checking the box that most accurately applies to you:

Symptom	Never	Mild	Moderate	Severe
Weight Gain				
Hair Loss				
Lack of Sexual Desire/Decreased Libido				
Inability to reach an orgasm				
Memory Loss/difficulty concentrating/brain fog				
Premenstrual tension syndrome (heavy or irregular periods)				
Hot Flashes				
Vaginal Dryness				
Night Sweats				
Headaches or migraines				
Cold all the time				
Depressed or unhappy				
Mood changes/Emotional swings				
Dry skin and/or hair				
Insomnia/ has a hard time sleeping				
Anxiety				
Painful Intercourse				
Fatigue/loss of energy				
Painful or swollen breasts				
Irritability				

Other symptoms or concerns you may be having:

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Authorization to Request Healthcare Information

Patient Name: ____

Date of Birth: __________________Social Security # ______________________

I request and authorize ______________________________ to release healthcare information of the patient named above to:

Valdosta Health & Wellness Clinic

3328 Bemiss Rd

Valdosta, Ga 31605 This request and authorization applies to:

□ Healthcare information relating to the following treatment, condition, or dates: ________________

____

____

□ All Healthcare Information

□ Other: ____

I understand that information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. (Federal law prohibits the disclosure of the above information without written consent of the patient or authorized representative.

I understand that I have a right to revoke this authorization at any time by presenting a written revocation to the medical records director or designee. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary, and that I need not sign this form in order to assure treatment.

Patient Signature x______________________________ Date: ________________

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Authorization to Release Healthcare Information

Patient Name: ____

Date of Birth: ________________________ Social Security #: ________________

I request and authorize Valdosta Health & Wellness Clinic to release healthcare information of the patient named above to:

Name: ____

Address: ____

Name: ____

Address: ____

Name: ____

Address: ____

This request and Authorization applies to:

□ All healthcare information.

□ Healthcare information relating to the following treatment, condition, or dates: ________________

____

□ Other: ____

I understand that information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. (Federal law prohibits the disclosure of the above information without written consent of the patient or authorized representative.

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I understand that authorizing the disclosure of this health information is voluntary, and that I need not sign this form in order to assure treatment.

Patient Signature x______________________________ Date: ________________

Billing Policy

- All private pay payments are due when services are rendered.

- We accept payments by cash, money order, and credit cards (Visa, MasterCard, and Discover). Checks are accepted for established patients only. There will be a $35.00 fee for returned checks.

- When checking in for your appointment, you should present your current insurance card to our receptionist at each visit. Please understand that our relationship is with you, not your insurance company. If we do not have all the necessary insurance information, we are unable to bill your insurance company and you will be responsible for the total charge at the time of your visit.

- We DO NOT file auto insurance or health insurance related to motor vehicle accidents. It is our policy that payment is made in full at the time services are rendered and the patient/guarantor will seek reimbursement from the responsible insurance. We will provide a copy of the receipt upon request for your reimbursement.

- Minors: It is the policy of Valdosta Health & Wellness Clinic that the person or parent accompanying a minor be responsible for payment of co-insurance, co-pays, and deductibles at the time of service. Divorce or custody agreements are between the two parties involved and not Valdosta Health & Wellness Clinic. We will provide a copy of the receipt for reimbursement. Patients aged eighteen and older are considered adults and will be responsible for their own accounts.

- The balance of your account remains your responsibility until the account is paid in full. If your insurance does not pay within 45 days, the balance in full is due by you, as well as any non-covered service by the insurance company, including cost of collection. This includes all Medicaid patients that do not notify us that you are over your 12 visit per year. If your account becomes past due for 120 days or more and no payment arrangement has been made, or no payment received for two consecutive months, the total bill will be turned over to our collection agency.

- If appointments are not rescheduled or canceled within 24 hours, you will be charged a missed appointment fee of $50.00, which cannot be billed to your insurance company. and is due in full before your next visit. If the appointment is a new patient appointment you will be charged $100.00 for a missed appointment, or late cancellation as these appointments take up more time than others. Two or more unjustified missed/canceled appointments, or 6 months without seeing your practitioner qualifies you to be automatically discharged from this practice. We do not have to inform you of this dismissal decision.

- You must reschedule your appointments, so that you may comply with your Practitioner's follow up orders unless approved by your practitioner. Failure to reschedule qualifies you as non-compliant and may result in a dismissal from the practice.

- A copy of all documents will be given upon request for a fee of .25 cent per page, with a notice of one week ahead of time.

Patient Signature x______________________________ Date: ________________________

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Non-Covered Services Medical Consent Form

I, ______________________________, understand that some services may not be considered eligible benefits (services and/or supplies may be determined to not be medically necessary such as labs, non-covered or investigational), by my health insurance provider. I understand that my health insurance coverage may have certain restrictions and limitations, such as authorization requirements and non-covered services. Examples of these non-covered items include, but are not limited to, labs, procedures or medical and supplies. I agree to be financially responsible for all related charges if they are not covered by my health insurance and payment is due when services are rendered.

Patient or Guardian signature x______________________________ Date: ________________

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Consent for Hormone Supplementation Therapy

I request and consent to the administration of hormones and oral supplements and authorize that these will be prescribed by the provider at Valdosta Health & Wellness Clinic. I acknowledge that there are no guarantees or assurances made with respect to the benefit of hormone supplementation therapy prescribed for me.

I understand that I will be in charge of injecting/administering these hormones and supplements prescribed to me. I will conform and comply with the recommended doses and methods of administration.

I understand that initial blood tests will be performed to establish my baseline hormone levels. I agree to comply with requests for ongoing testing to assure proper monitoring of my hormone levels. I agree to report to the provider any adverse reaction or problems that might be related to my hormone therapy. I understand that with hormone supplementation there are possible risks and complications if I do not comply with the recommended dosage.

I have not been promised or guaranteed any specific benefit from the administration of this therapy. I understand that hormone supplementation for rejuvenation purposes is a new specialty and there are no guarantees with respect to the treatment prescribed.

I understand that the role of the provider is for hormone replacement only. I agree that I am and will be under the care of another physician for all other medical conditions.

I have been informed that insurance companies and Medicare do not pay for hormone supplementation therapy. I therefore agree to pay for all services including laboratory and pharmacy charges myself, with the understanding that I will not be reimbursed by my insurance company.

I have read and understand all the above consent. I have had other information given to me about hormone supplementation therapy so that I fully understand what I am signing and hereby request and consent to treatment using hormone supplementation therapy.

Name____

Signature ______________________________ Date______________________________

CANCELLATION/NO SHOW POLICY

- **Our goal is to provide quality medical care within a timely manner. In order to do so, we have established a new cancellation/no show policy. This policy will help ensure that appointment times are available throughout the day.**

- **NO SHOW POLICY: A "NO SHOW" status is defined as a patient who has failed to be present at the time of their scheduled appointment, or fails to provide a 24-hour cancellation notice.**

- **We understand that life can get busy, and schedules can change. If you need to cancel or reschedule an appointment, please contact our office 24 hours in advance of your scheduled appointment time.**

- **Failure to provide a 24-hour cancellation notice, or failure to show up to scheduled appointment will result in a $50 no show fee unless the appointment was considered a new patient appointment. No show fee will have to be paid prior to next visit.**

- **New patient appointments take up more time than that of a regular patient visit. Failure to show up to your first scheduled appointment, or provide a 24-hour cancellation notice will result in a $100.00 no show fee that will be deducted from the card you provided to us upon scheduling your first appointment.**

- **Failure to settle any acquired no show debts will result in your account being sent to collections.**

The intent of this policy is to prevent delays in care and utilize provider time more efficiently by reducing unused appointment slots. We appreciate your attention to our new NO SHOW POLICY, and request that you comply with all cancellations in a timely manner.

Patient Signature: ________________________________ **Date**____________________________