Valdosta Health & WELLNESS CLINIC

A NEW BEGINNING, NATURALLY

Patient Information

Legal Name: _____ Preferred Name: _____
(Last, First, Middle initial)

Address: _____
(Street) (City, State & Zip)

D.O.B: _____ SS#: _____ Email: _____

Cell Phone: _____ Home Phone: _____

Preferred contact method: Circle all the apply *PHONE* *EMAIL*

Sex: _____ Marital Status: _____ Race: _____

Occupation: _____ Work Number: _____

Insurance Information

Selfpay: *YES* *NO*

Primary Insurance: _____ Ins Phone Number: _____

ID Number: _____ Group Number: _____

Secondary Insurance: _____ Ins Phone Number: _____

ID Number: _____ Group Number: _____

Account Holder: _____ D.O.B: _____

Relation: _____ Phone Number: _____

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.

Signature: _____ Date: _____

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 *(R63.5)*				
Hair Loss *(L65.9)*				
Decreased Libido *(R68.82)*				
Inability to ejaculate *(F52.32)*				
Memory Loss/Brain fog *(R41.840/ R41.9)*				
Increased urinary urge				
Decreased urine flow				
Lack of motivation				
Night sweats *(R61.9)*				
Bone Loss				
Loss of muscle mass or tone				
Depressed or unhappy *(F32.9/ R45.2)*				
Mood Changes/ Emotional *(F39/ R45.86)*				
Dry skin or hair *(L85.3)*				
Insomnia *(G47.00)*				
Anxiety *(F41.9)*				
Decreased erections				
Fatigue/ no energy *(R53.83)*				
Backache, joint pain, or stiffness				
Irritability *(R45.4)*				

Other:_____

Have you ever been on any Bio-Identical Hormone Replacement Therapy? If yes what where you prescribed?_____

_____

What goals are you trying to reach with doing BHRT?_____

_____

Medication List

List any medications, vitamins, and supplements you are currently taking.

	Name	Strength	Dose	Amount per day	Diagnosis
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

Pharmacy Information

Preferred Pharmacy:_____
Preferred Compounding Pharmacy:_____

- Certain pharmacies that we use for compounding are out of state. If your shipping address is different from your billing address please specify shipping address below so we can inform any out of state pharmacies. It cannot be a P.O box.

Address:_____

_____

Past Medical History

Drug Allergies:

List the name of the med and side effect below.

1._____,_____

2._____,_____

3._____,_____

4._____,_____

5._____,_____

6._____,_____

7._____,_____

8._____,_____

9._____,_____

10._____,_____

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

☐Diabetes ☐Hypertension ☐Heart Disease ☐Psychiatric Problems

☐Rheumatic Fever ☐Mitral Valve Prolapse ☐UTI ☐Hepatitis/Liver Disease

☐Varicosities/Phlebitis ☐Asthma ☐Lung Disease ☐Hypo/Hyperthyroidism

Other:_____

Do you have any Autoimmune disorders?_____

Do you have any Thyroid problems?_____

Have you ever had any type of Cancer? _____

_____

Surgical History

List all Surgeries you have had in the past. List the name,date,reason.

1._____,_____,_____

2._____,_____,_____

3._____,_____,_____

4._____,_____,_____

5._____,_____,_____

Hospitalizations

1._____,_____,_____

2._____,_____,_____

3._____,_____,_____

4._____,_____,_____

5._____,_____,_____

_____

Family History

Breast Cancer	☐ Yes	☐ No	Relation:_____	Living:_____
Colon Cancer	☐ Yes	☐ No	Relation:_____	Living:_____
Ovarian Cancer	☐ Yes	☐ No	Relation:_____	Living:_____
Osteoporosis	☐ Yes	☐ No	Relation:_____	Living:_____
Diabetes	☐ Yes	☐ No	Relation:_____	Living:_____
Hypertension	☐ Yes	☐ No	Relation:_____	Living:_____
Heart Disease	☐ Yes	☐ No	Relation:_____	Living:_____
Kidney Disease	☐ Yes	☐ No	Relation:_____	Living:_____

Social History

Do you smoke cigarettes?_____ How long?_____
Do you use street drugs?_____What kind?_____
Do you drink alcohol?_____
How much alcohol per day,week,month?_____
How would you describe your overall general health?_____
Do you exercise?_____If yes how often?_____
Are you on any type of diet for weight-loss?_____If yes what diet?_____
Are you on any special diet (ex: gluten free)?_____
Have you ever suffered from an eating disorder?_____if yes what type?_____
Have you ever been diagnosed with any vitamin deficiencies?_____ if yes what type? _____
Have you ever been diagnosed as iron deficient anemic?_____

_____

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Authorization to Release Healthcare Information

_____ _____
Name Date

I request and authorize Valdosta Health & Wellness Clinic to release healthcare information of the patient listed above to: (ex: family or providers)

NAME	RELATION	ADDRESS	PHONE

This request and authorization applies to:

___ All Medical Records ___ History & Physical ___ Progress Notes

___ Lab Reports ___ Medication Record ___ Imaging Reports

___ Other

I understand that information in my health record may include information relating to sexually transmitted diseases, AIDS, or 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 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 I need not sign this form in order to assure treatment.

_____ _____
Signature Date

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Authorization to Request Healthcare Information

Name _____ Date of Birth _____

I request and authorize the facility listed below to release healthcare information of the patient named above to: Valdosta Health & Wellness Clinic location at 3328 Bemiss Road Valdosta, Ga. 31605

FACILITY NAME	ADDRESS

This request and authorization applies to:

___ All Medical Records ___ History & Physical ___ Progress Notes

___ Lab Reports ___ Medication Record ___ Imaging Reports

___ Other

I understand that information in my health record may include information relating to sexually transmitted diseases, AIDS, or 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 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 I need not sign this form in order to assure treatment.

Signature _____ Date _____

Billing Policy

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

- We accept payments by cash, money order or credit cards. Checks are accepted for established patients only. There will be a $40 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.

- 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, deductibles, etc. 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 18 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 30 days, the balance in full is due by you, as well as any non-covered service by the insurance company, including cost of collection. If your account becomes past due for 30 days or more and no payment arrangement has been made, the total bill will be turned over to collections.**

- A copy of all documents will be given upon request for a fee of 0.35 cent per page, with a notice of one week ahead of time.

_____ _____

Signature Date

No Show Policy

- If appointments are not rescheduled or canceled atleast the day before the appointment, 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 appointment.

- 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 appointments, or 6 months without seeing your practitioner qualifies you to be discharged from this practice. We do not have to inform you of the dismissal decision.

- You must reschedule your appointments, so that you 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.

- 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 appointments. We appreciate your attention to our policy.

_____ _____

Signature Date

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 services include, but are not limited to, labs, procedures, or medical supplies. I agree to be financially responsible for all related charges if they are not covered by my health insurance plan. I understand that payment is due when services are rendered.

_____ _____

Signature Date

Blood work

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

- It if your responsibility to find out what lab company your insurance will cover. Labs can be drawn in our clinic with a $35 venipuncture fee that we do not bill to your insurance. We can have labs drawn in our office processed and billed by Quest or Labcorp.

- Knowing exactly what your insurance will and will not cover will help eliminate the possibility of unexpected expenses.

- Follow up hormone and thyroid labs will need to be drawn in the morning as soon as possible. Thyroid medication will need to be taken the morning of labs and hormone medication will need to be taken the night before to ensure accurate results.

- Patients that are taking Testosterone injections will need to have labs drawn 4 days after your last injection.

_____ _____

Signature Date

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 responsible for self-administration/injection of the hormone medications and supplements prescribed to me. I will conform and comply with the recommended doses and methods of administration.

I understand that initial laboratory blood tests will be performed to establish my baseline hormone levels. I agree to comply with requests for ongoing laboratory blood testing to assure proper monitoring of my hormone levels. I agree to contact my provider if I experience any adverse reactions or problems that may be related to my hormone therapy. I understand that failure to strictly follow prescribed/recommended medication/supplementation dosages can result in complications and health risks.

I understand that breast health is an important part of women's health. In order to be treated for hormonal imbalances, I understand that I am required to schedule and complete an initial breast Thermogram and /or Mammogram. Thermography is a non-invasive, radiation free, touch- free, thermal imaging process which provides multi-colored, thermal images of body tissue. Thermography has been proven to identify early onset changes to breast tissue that are not typically visible in the early stages of tissue change when utilizing traditional mammography. Thermography establishes and provides a baseline of my breast health, which allows my provider to monitor and manage any early indications of changes to the breast tissue. I understand that I will be required to complete follow-up thermograms as needed and prescribed by my provider. I understand that most insurance companies do not offer coverage for Thermography and my insurance company will not be billed for this service. I understand that payment for Thermography services is my responsibility. We also need a current copy of your up to date pap smear.

I have not been promised or guaranteed any specific benefit from the administration of Hormone Supplementation 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 provider's services include, and are limited to, hormone replacement therapy, management of thyroid function, and weight loss. I understand and agree that I must seek the services of another provider for all other medical conditions.

I have been informed that most insurance companies and Medicare do not provide coverage for hormone supplementation therapy. I understand that I am financially responsible for all non-covered services including pellet insertions as prescribed, laboratory blood tests, and pharmacy charges for non-covered medications. I understand that I will not be reimbursed by my insurance company.

I have read and understand this Consent for Hormone Supplementation Therapy. I understand that, to ensure my thoroughunderstanding of my treatment plan, additional information will be provided to me.

Name **Date**

_____ _____

Signature

_____