NORTHDALLASWELLNESS CENTER

Hormone Therapy Questionnaire

(ALL INFORMATION CONTAINED IN THIS QUESTIONNAIRE IS STRICTLY CONFIDENTIAL, WILL BE PROTECTED TO THE HIGHEST OF HIPAA STANDARDS, AND WILL BECOME PART OF YOUR NDWC MEDICAL RECORD.)

Name (First, M.I., Last) _____

E-mail_____ SSN _____ - _____ - _____

Address (street) _____

(city) _____ (state) _____ (zip) _____

Phone (work) _____ (cell) _____

(fax)_____ Occupation _____

Date of birth_____ Gender: □ Male □ Female Height _____ Weight _____

Primary Physician (name) _____ Phone _____

Date of last physical with your physician _____ Results _____

LIFESTYLE	**YES**	**NO**	
Do you smoke?	□	□	If yes, how much per day _____
Do you drink alcohol?	□	□	If yes, how much per day _____
Do you drink caffeine?	□	□	If yes, how much per day _____
Do you exercise?	□	□	If yes, please describe _____

FAMILY HISTORY **age; significant health issues**

Father _____

Mother _____

Brothers/Sisters_____

PERSONAL MEDICAL HISTORY

Medical conditions _____

_____

_____

_____

_____

Surgeries _____

_____

Current medications (Name, dosage, frequency) _____

_____

_____

_____

Medication or food allergies_____

_____

Current vitamins and supplements _____

_____

Your local pharmacy name _____ Phone number_____

Address _____

HRT/TESTOSTERONE TREATMENT CHECKLIST

	YES	NO		YES	NO
Decreased sense of well-being	☐	☐	Thinning or loss of hair	☐	☐
Difficulty sleeping	☐	☐	Heat or cold intolerance	☐	☐
Decreased energy	☐	☐	Decreased skin tone	☐	☐
Decreased concentration, memory	☐	☐	Mood swings	☐	☐
Decreased sex-drive	☐	☐	Sadness, depression	☐	☐
Decreased muscle strength	☐	☐	Hot flashes	☐	☐
Increased fat deposits	☐	☐	Prolonged exercise healing	☐	☐

MEN ONLY

Have you had a kidney, bladder or prostate infection in the last 12 months? _____

Do you have blood in your urine? _____ Date and result of last PSA test _____

WOMEN ONLY

Date of last menses_____ Number of pregnancies _____ Number of live births _____

Are you pregnant or breast-feeding? _____ Type of birth control _____

Most recent mammogram and results_____ Most recent Pap and results _____

Have you ever been on any hormone therapy before? If yes, please explain_____

_____

Have you ever been on testosterone replacement in the past? If yes, please explain _____

_____

New patient notice:

North Dallas Wellness Center has set aside 60 minutes for your first consultation with Dr. Fein. Unfortunately, the number of patient no-shows has increased, which prevents other patients from access to timely and convenient appointments. NDWC will request a credit card number to "hold" this hour-long time slot. Regrettably, in the event of a "no-show," a $100 fee will be charged.

PATIENT AGREEMENT FOR TREATMENT

North Dallas Wellness Center is an Insurance Free Entity.

THIS AGREEMENT is made and executed on ____ (day) of _____ (month), 2019, between North Dallas Wellness Center (hereafter called "NDWC") and _____ (hereafter called "Patient").

IN CONSIDERATION of North Dallas Wellness Center providing Patient with medical management, administrative, and follow-up services, Patient understands and agrees to the following:

Patient understands that he/she will not request North Dallas Wellness Center to submit a claim to any third party payor, even if patient is entitled to benefits, for any portion of the fee or any services rendered to patient. North Dallas Wellness Center will not accept assignment from any third party payor as payment for services. **Patient understands that Medicare, Medicaid, and Champus require a waiver that states the patient acknowledges the waiving of rights to file a claim to seek reimbursement from these entities or secondary insurance coverage. _____**

MEDICAL HISTORY QUESTIONNAIRE: Patient will submit a truthful, accurate, and complete Medical History Questionnaire. Patient also acknowledges that failure to provide accurate, truthful, and complete information on this Questionnaire or to the Physician(s) of North Dallas Wellness Center could result in inappropriate treatment. _____

AUTHORIZATION: Patient authorizes NDWC to obtain, on Patient's behalf, medical laboratory, diagnostic testing, Physician(s) consulting, and compounding pharmacy supplies. In addition, Patient authorizes NDWC and the Physician(s) to provide medical care and prescribed pharmaceuticals based on the Medical History Questionnaire, laboratory testing, and other information submitted to NDWC under this agreement. _____

INSTRUCTIONS AND TREATMENT: Patient understands and agrees to comply with the method of instruction, treatment and dosage schedules prescribed by Physician(s); to immediately cease any medical treatment prescribed by Physician(s) in the event of an adverse reaction or side effect arising from prescribed treatment; and to immediately provide NDWC and Physician(s) with written notice *via email to drfein@DrDavidFein.com* of any such adverse reaction or side effect. Patient understands and agrees that diagnosis and treatment of any medical condition may involve certain risk. _____

PRIMARY CARE PHYSICIAN: *Patient represents that he or she is under the care of a primary care Physician* and that Patient will not rely or substitute the advice of NDWC Physician(s) should it conflict with the advice of the Patient's primary care Physician. Patient agrees to notify his or her primary care Physician that Patient is receiving HRT. _____

LABORATORY FEES: North Dallas Wellness Center will obtain laboratory testing from certified and registered labs in Texas, including QuestLab and LabCorp. Patient understands and agrees that patient's insurance coverage may involve co-pays and/or deductibles, which may require patient to be financially responsible for laboratory fees. _____

HORMONE REPLACEMENT THERAPY: Patient understands and agrees that, although each hormone has been approved by the FDA, the FDA only approves or denies usage of products made by manufacturers which are produced in a specific dosage and form. Therefore, the FDA does not approve or disapprove of hormones which are given in an individual dosage or form for each patient by Physician(s) of NDWC. I also understand that Physician(s) may choose to discuss with me and provide medications that are off-label in order to offer the widest range of therapies possible. Off-label prescribing is a common and legal practice by most physicians in the US whereby medications are prescribed for purposes other than originally approved. _____

WARRANTY: Patient understands and agrees that the methods of medical treatment offered by NDWC and Physician(s) are not accompanied by any claims, guarantees, or warranties. This agreement remains in effect until revoked by Patient in writing, and photocopies of this assignment shall be construed as valid as the original. _____

EMAIL COMMUNICATION: Patient understands and agrees that NDWC offers communication via email for non-urgent matters such as lab results. Although NDWC has implemented reasonable technical safeguards, NDWC cannot guarantee privacy, security, or confidentiality of emails sent or received. NDWC is not responsible for emails that are lost due to technical failure during composition, transmission, or storage. NDWC will not forward emails to third parties without your prior written consent, except as authorized or required by law. Until new technologies are adopted by NDWC, patient understands and agrees that email communications are not encrypted. NDWC RESPECTS AND PROTECTS THE PRIVACY OF OUR PATIENTS. NDWC WILL NEVER SELL OR RENT YOUR EMAIL ADDRESS TO THIRD PARTIES. You may discontinue receiving emails as a means of communication by sending an email or letter to NDWC. _____

RESCHEDULING OR NO-SHOW: If patient needs to reschedule or cancel appointment, he/she agrees to notify North Dallas Wellness Center within 24 hours of scheduled appointment. Patient understands that failure to do so may result in a $75 fee. _____

_____ _____

Patient Printed Name Patient Signature

_____

Date