NEW PATIENT FORM

DATE: _____

NAME: _____DATE OF BIRTH: _____

ADDRESS: _____
_____

EMAIL:_____

CELL: _____
TELEPHONE:(Home):_____

Agreement to receive voice and text reminders for scheduled appointments: Yes___No____

How did you hear about The Menopause Center? _____
INSURANCE INFORMATION: _____
MEMBER ID: _____ GROUP#_____
Pharmacy name:_____
Address:_____

Consent for Treatment:

I hereby authorize the Physician or Nurse Practitioner to treat me as is appropriate for my medical condition. I understand that Registered Nurses and/or Medical Staff members may be involved in my care under the direction and supervision of the physician.

_____
Signature of Patient

Consent for Photographs:

Certain vulva disorders are best treated when we have vulva photos taken prior to treatment. If recommended, the physician or nurse practitioner will ask you for verbal consent prior to taking any vulva photos.
I (patient) consent to vulva photographs, if recommended, to be taken and kept in my electronic medical record.

_____
Signature of Patient

Financial Policy:

Thank you for choosing The Menopause Center for your care. We understand that medical care is expensive and that health insurance premiums are expensive. The reason that we have chosen the path of not participating with insurance plans is to offer you a better form of medicine. You will have more time with your physician and will have more frequent physician follow up appointments to monitor your progress. Dr. Hall will search for the root cause of your problem and will prescribe a plan of action tailored specifically for you. This type of medical care, not dictated by the rules of the insurance companies is better and we are motivated daily by our excellent results. Remember that optimal health is your single most important asset.

Please review the information below, then enter the date and sign on the beck to indicate that you have read and fully understand our financial policy. If you do not understand any part, please ask for an explanation.

Insurance:

We do not participate in any insurance plans, and therefore we expect payment in full at the time of visit. Any contract that you may have with an insurance company is between you and that company. We are not part of that contract. At the time of payment, we will give you a "superbill" which includes the services provided in the office and the accompanying diagnosis. The superbill will have the proper codes and is ready to attach to an insurance claim form that you download from your insurance company website for reimbursement. It is each patient's responsibility to check with their insurance carrier for information on their policies, benefits, and procedures.

HMO plans will NOT pay for out of network providers. Some PPO plans may pay 80% of their reduced fee schedule after your deductible. The deductible for out of network may be separate or higher than the in-network deductible. Many PPO plans pay for annual visits and are not subject to a deductible

Medicare: We are not Medicare providers, and we have "opted out". This means that Medicare will not pay for our services, however some laboratory fees may be paid by Medicare. Your secondary insurance generally will not cover our services and it is recommended that you check with them regarding their payment policies prior to your visit.

Health Savings Plans: Most of our services are eligible for reimbursements through your Health Savings Account. Bring your HSA credit card with you to your office visit.

Reimbursement for laboratory tests: Pap smears and cultures--billed as an "in network" provider by the lab. Microscopic exam for vaginal infection, urine dipstick-in office tests that are billed by our office may be a covered service by your insurance.

Bloodwork:

In-house option

The blood is drawn and sent from our office, saving you time and money. We offer discounted prices from the retail lab prices, usually 50% or more lower price. Our in-house option is often cheaper than going to the lab and paying 20% of the higher price and it is cost effective for anyone with a high deductible. The blood work charges are included in your superbill that you can submit for out of network benefits. We give you the total price before we draw your blood.

l. At the Lab Option: You can always go to the lab to have your blood drawn. It is best to make an appointment with Quest or Lab Corp. We will give you a request for the ordered blood work. The lab will then bill your insurance directly as an in-network provider. In general, you are subject to 20% of the cost of each lab test if covered or 100% if your insurance decides the test is "not necessary", and therefore not covered. It is impossible to reliably know if your insurance will pay) for specific tests ahead of time. You will be billed the lab rate for uncovered labs.

2. Specialized hormone testing is necessary, in most cases. It is one of the important tools we use to find the source of your problem and is usually not covered by insurance. The price of the test will be discussed with you before the test is done.

3. Testing done with Genova (stool, NutrEval) are set fees by Genova, paid to Genova by patient. Genova does bill insurance. We do charge a drawing fee for the blood work in our office.

Additional Fees:

Missed Appointments — A fee of $300 is charged for an appointment that is not canceled within 48 business hours. The reason for this charge is that we must keep a full schedule to run our business. If you cancel with little warning, we do not have time to fill the appointment slot.

Fees for services provided may be adjusted for time or services rendered.

Copy records fee- $25 per request and .50 per page up to 50 pages, then .25 per page thereafter

Prior authorization (medication) - $50

Letter Fee - $25 (includes letters of necessity for both insurance companies and patients)

Returned Checks - $25 plus any fees charged by our bank

Print name: _____

Signature: _____

Date: _____

The Menopause Center PLLC HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed out notice before signing this consent.

The terms of the notice may change, if so. you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to with this restriction, but if we do, we shall honor this agreement. The (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, OR healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions. • The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. t) nie practice may condition receipt of treatment upon execution of this consent.

May we leave a message on your cell phone? Yes____No_____

May we discuss your medical condition with any member of your family? Yes_____ No_____

If YES, please name the members allowed:

_____

_____

Signature: _____ Date: _____

CONFIDENTIAL FEMALE EVALUATION

Date: _____

Name: _____ Birth Date: _____Age: _____
Referred by: _____
Marital Status: _____ Occupation: _____
Height: _____ Weight: _____ BMI: _____Last Menstrual Period: _____
Reason for today's visit:
_____
_____
_____

Question:	If YES, how often and how much?	Please Check, NO
Do you use tobacco?		
Do you use alcohol?		
Do you use caffeine?		
Do you exercise?		

Any Latex or Adhesive allergy or sensitivity? Yes_____ No _____
Betadine Allergy? Yes _____ No _____
List any DRUG allergies and describe the reaction that occurred:
_____
_____
_____
_____
_____

Current Prescription Medications & Over-the-Counter medications, vitamins, and supplements:
_____
_____
_____
_____
_____
_____

Medical Conditions or Problems:

_____
_____
_____
_____
_____

Past Surgical History:

_____
_____
_____
_____
_____

Past Gynecological History/Treatment:

_____
_____
_____
_____
_____

Past Gynecological Surgeries/Date of Surgery/Reason for Surgery:

_____
_____
_____
_____
_____

How many pregnancies have you had? _____ How many children? _____
Vaginal Births _____
C-Sections _____
Living Children _____

Additional Information:

_____
_____
_____
_____
_____
_____

FAMILY HISTORY

Relationship	Medical Problem/ Age of onset	Current Age/Age of death
Mother		
Father		
Sister		
Brother		
Children		
Other		

Have you had any of the following tests performed?

TEST	YES/NO	DATE	RESULTS
Mammography			
PAP Smear Any Abnormal?			
Bone Density			
Pelvic Sonogram			
Colonoscopy			
Cologaurd			

_____

_____

Please list any doctors you have seen within the past year and the reason for the visit:

Healthcare Provider	Specialty	Reason

*** Please include a copy of all relevant lab work, especially hormone levels that you have recently obtained.

Do you want Dr. Hall to send a copy of your office visit today to any of your providers? Yes____ No____ If yes, please list the providers:

_____
_____
_____
_____

Name: _____

Date: _____

Services of interest to you: (Please check)

___Bio-identical hormones for menopause

___Testing for hormone balancing (DUTCH test)

___Hormone Pellets (for low libido)

___ Nutrient testing for nutritional deficiencies

___ Customized Nutritional Supplements upon completion of testing

___Food Sensitivity Testing

___ Stool test for stomach or bowel issues

___ Mona Lisa Touch-Laser for Vaginal Rejuvenation

____ PRP Shot-May help with Sexual Response

___Botox for facial wrinkles

Name: _____

Date: _____

Have you had any of these symptoms in the last <u>3 months</u>?

SYMPTOMS	NEVER	MILD	MODERATE	SEVERE
Hot Flashes				
Night Sweats				
Bleeding after Menopause				
Vaginal Dryness				
Decreased Sex Drive				
Decreased Sexual Response				
Painful Intercourse				
Irregular Periods				
Hair Loss				
Skin Problems				
Irritability				
Anxiety				
Difficulty Falling Asleep				
Difficulty Staying Asleep				
Fatigue				
Memory Problems				
Migraine Headaches				
Breast Tenderness				
Muscle/Joint Pain All Over				
Constipation				
Diarrhea				
Weight Gain				
Bloating After Eating				
Urinary Frequency				
Urinary Incontinence				
Frequent UTI’s				
Vulva Pain or Burning				
Vulva Lesion				
Vaginal Discharge (Chronic)				