BASIS MEDICAL

MALE INTAKE FORMS

FIRST & LAST NAME: _____ NICKNAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CONTACT NUMBER: _____ DRIVER LICENSE NUMBER: _____
(copy is required at check-in)

EMAIL: _____ OCCUPATION: _____

HEIGHT: _____ CURRENT WEIGHT: _____ GOAL WEIGHT: _____ BP IF KNOWN: _____

BIRTH DATE: _____ AGE: _____

EMERGENCY CONTACT: _____ CONTACT #: _____ RELATIONSHIP: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ DOMESTIC PARTNER

PRIMARY PHYSICIAN: _____ DATE OF LAST VISIT: _____

LIST ANY MAJOR HOSPITALIZATIONS, OPERATIONS OR ILLNESS: _____

_____

LIST YOUR PRIMARY SYMPTOMS OF CONCERN YOU WANT TO ADDRESS BY PRIORITY

SYMPTOMS/CONCERN	DATE OF ONSET	FREQUENCY	SEVERITY
EXAMPLE: HEADACHES	JANUARY 2018	4 X WEEKLY	MILD MODERATE, SEVERE

IMPORTANT- PLEASE READ CAREFULLY BEFORE SIGNING: I certify the information provided is true and correct and that I am a competent adult of at least 18 years of age, or that I am minor, under the age of 18, I understand that the consent of my parent/guardian/person having legal custody will be required before treatment. FURTHER, I UNDERSTAND A COMPLIMENTARY CONSULTATION IS PROVIDED BY THE PHYSICIAN'S APPOINTED NON-MEDICAL REPRESENTATIVE AND IS STRICTLY TO PROVIDE PROGRAM/TREATMENT INFORMATION.

Patient Signature _____ Date _____

FAMILY HISTORY INFORMATION- CHECK ALL THAT APPLY

CHILD	SIBLINGS	FATHER	MOTHER	SELF	DISEASES/DISORDERS	PHYSICIAN NOTES
					Abnormal Blood Pressure	
					Arthritis/Joint Problems	
					Asthma, Bronchitis	
					Autoimmune Disease	
					Blood Disorders/Anemia	
					Cancer/Tumors/Cysts	
					Colitis	
					Crohn's Disease	
					Depression/Mental Illness	
					Diabetes	
					Eczema/Psoriasis	
					Endocrine Disorder	
					Epilepsy	
					Excessive Bleeding	
					Gallstones	
					Heart Disease	
					Herpes/Cold Sores	
					High Cholesterol/Lipids	
					HIV	
					Hepatitis	
					Hpv/Human Papillomavirus	
					Jaundice/Liver Disease	
					Keloid Scarring	
					Kidney Infections/Stones	
					Emphysema	
					Melanoma/Skin Cancer	
					Parasites	
					Phlebitis/Varicose Veins	
					Pneumonia	
					Reoccurring Infections	
					Rheumatic Fever	
					Rheumatoid Arthritis	
					Thyroid Disease	
					Tuberculosis	
					Seizures	
					Stroke	
					Ulcers	

PLEASE LIST CURRENT RX MEDICINES & USED IN THE PAST 6 MONTHS

CHECK ALL THAT APPLY

Bloating, Gas Flatulence	
Heartburn, Reflux	
Constipation	
Hemorrhoids	
Bowel Habit Changes	
Coughing/Wheezing	
Fatigue	
Cravings-Sweets	
Craving-Salt	
Cravings-Beer, Wine, Liquor	
Arthritis/Joint Aches	

Hair Loss-falling out	
Dry Hair	
Thinning Hair	
Nausea/Vomiting	
Ears Ringing/Dizziness	
Sensitive to Cold	
Tired Upon Waking	
Frontal Headaches/Sinusitis	
Cold Hands/Feet	
Lower Back Pain	
Depression/Weepiness	

Palpitations/Flutters	
Difficulty Getting to Sleep	
Insomnia	
Psoriasis/Acne Flareups	
Dry Skin	
Food Allergies	
Seasonal Allergies	
Poor Circulation	
Puffy Face/Swollen Eyelids in AM	
Urinary Tract Infections	
Anxiety/Irritability, Temper	

SCORE USING THE FOLLOWING: 0=NEVER 1=SOMETIMES 2=REGULARLY 3=OFTEN 4=CONSTANTLY

Hair Loss On Top Of Head	
Depressed	
Swollen Belly	
Irritable & Aggressive Behavior	
Loss Of Self Control	
Restless, Light Sleep	
Anxious	

Face Wrinkled & Slack	
Loss Of Muscle Tone	
Increased Belly Fat	
Fatigues, Feeling Exhausted	
Reduced Libido	
Memory Lapses/Mental Fog	
Weight Gain-hips, Waist, Thighs	

SCORE USING THE FOLLOWING: 0-10, WITH 10 BEING THE HIGHEST

Current Level Of Back Pain	
Current Level Of Join Pain	

Stress Level Past 30 Days	
Stress Level Past 6 Months	

Energy Level In Morning	
Energy Level In Late Afternoon	

THERAPY MANAGEMENT AGREEMENT

This agreement between _____("Patient") and Basis Medical LLC ("BM") establishing guidelines and conditions for the use of hormone replacement therapy ("HRT") involving DEA "controlled" or "scheduled" medication. BM and patient agree that these guidelines and conditions are an essential factor in maintaining a successful patient/practitioner relationship. Adverse side effects and/or physical/psychological dependence may develop after repeated use of these medications and, therefore, these agents are prescribed with caution.

The patient agrees and accepts to the following conditions:

1. I understand that the medications I am receiving or will receive are prescribed for me based on diagnoses derived from my submitted medical history, and the results of lab work and physical examination. The medications are to be used exclusively for treatment of hormonal deficiencies and related medical conditions in accordance with applicable state and Federal Law.
2. I understand and agree that no medical treatment or medication provided to me by Basis Medical LLC will be used for the purposes of body building, performance enhancement or physical appearance.
3. I certify that the answers I provided to the health questions on the Health History laboratories are accurate and correct to the best of my knowledge and that I have not been coached by any third party nor have I knowingly been deceptive for secondary gain, for medical treatment or prescription of a medication.
4. I will not attempt to obtain HRT medications from any other healthcare practitioner without disclosing my current medical usage of HRT or other medication. I understand that it may be against the law to do so.
5. I have discussed and understand the risks and benefits associated with HRT. I will immediately reports any adverse side effect related to the use of my HRT to Basis Medical, LLC and discontinue use until advised to resume usage by Basis Medical. I voluntarily assume any and all possible risks which may be associated with HRT.
6. I understand that representatives of Basis Medical and/or Licensed Physician Assistant are available for questions and/or concerning during normal business hours throughout the course of my treatment.
7. I agree that the HRT medications from the pharmacy designated by Basis Medical are for my personal use only and for no other purpose. I will not share, sell, or trade my medications. I will safeguard my medications from loss or theft and will be responsible for their safekeeping.
8. I will be able to purchase the medications from the pharmacy designated by Basis Medical and the pharmacy will send medication directly to me. I understand I have the right to purchase my medication from any pharmacy of my choice. If I choose to obtain medication from a pharmacy of my own, I must notify Basis Medical in writing of my intention to do so and include the name of the pharmacy in my request.
9. I agree and understand that federal regulations prohibit the return of prescribed medications.
10. I understand that HRT treatment are not covered by health insurance. I agree that all services and medication provided to me by Basis Medical or its associated providers are to be paid for in advance. I will not seek reimbursement through my health insurance company, Medicare, Medicaid, or other third party payer.
11. I agree that the Basis Medical patient/physician relationship is not intended to replace the existing patient/physician relationship with my current primary care provider (PCP) and the treatment provided by Basis Medical will be in conjunction with the care provided by my current PCP.
12. I agree that I will use my medication at the prescribed rate and dosage and will keep the medication in its respective labeled container.
13. I understand that Basis Medical only treats patients over the age of 30 with documented symptoms of hormone deficiencies (Hypogonadism and Adult Growth Hormone Deficiency). No prescription will be provided unless a clinical need exists based on required lab work, physician consultations, and current health history though either patient's personal physicians or a Basis Medical - affiliated physician. Agreeing to lab work does not automatically qualify patient to clinically necessity and prescription of HRT.

I have read and agree to the terms of this the Therapy Management Agreement.

PATIENT SIGNATURE: _____

PATIENT NAME: _____ DATE: _____

BASIS MEDICAL

HEALTH INSURANCE INFORMATION

NAME OF YOUR HEALTH INSURANCE CO. _____

POLICY #: _____ GROUP #: _____

INSURED'S NAME (if different than yours): _____ INSURED'S SS#: _____

RELATIONSHIP TO INSURED: _____ INSURED'S BIRTH DATE: _____ EMPLOYER: _____

SECONDARY INSURANCE INFORMATION

NAME OF YOUR HEALTH INSURANCE CO. _____

POLICY #: _____ GROUP #: _____

INSURED'S NAME (if different than yours): _____ INSURED'S SS#: _____

RELATIONSHIP TO INSURED: _____ INSURED'S BIRTH DATE: _____ EMPLOYER: _____

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

Signature of Patient/or Guardian of said Minor _____ Date _____

FINANCIAL AUTHORIZATION

I also clearly understand that if I do not follow the Doctors and/or physician's specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits to be directed to the Doctor and/or physician for all services rendered. I understand in the event my account goes to collection, I am responsible for any and all collection fees.

I understand that I am financially responsible for all fees incurred for the services provided, regardless of any applicable insurance or benefit payments, and agree to ensure full payment. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or an applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

NAME OF GUARANTOR (person responsible for guaranteeing payment for all services) _____

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this assignment.

_____	_____	_____	_____
Patient's Name Printed	Date	Patient's Signature	Date

_____	_____	_____
Minors Name	Guardian/Spouse's Signature of Authorizing care for Minor	Date

I hereby authorize Basis Medical, LLC to administer care as deemed necessary to my child, a minor under the age of 18 years old.

Improving Health, Wellbeing & Performance
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NOTICE OF PRIVACY PRACTICES- ACKNOWLEDGMENT & CONSENT (CONSENT TO USE PHI)

Acknowledgment for Consent and Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Basis Medical, LLC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use of disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

_____	_____
Patient or Legally Authorized Individual Signature	Date
_____	_____
Print Patient's Full Name	Time of Day
_____	_____
Witness Signature	Date

AUTHORIZATION OF CARE

This clinic will attempt to identify and diagnose any ailments you may have that may be corrected through physical medicine, massage therapy, chiropractic care, and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known these things which otherwise might not come to the attention of the physician (deformities, illness, etc.). I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or not, by binding arbitration under the current malpractice terms which can be obtained by written request.

I also clearly understand that if I do not follow the Doctors and or/physician's specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminated my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor and/or physician for all services rendered. I understand in the event my account goes to collections, I am responsible for any and all collection fees.

I understand that I am financially responsible for all fees incurred for the services provided, regardless of any applicable insurance or benefit payment, and I agree to ensure full payment. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits clam submissions.

Name of Guarantor (person responsible for guaranteeing payment for all services) _____

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____	_____	_____	_____
Patient's Name Printed	Date	Patient's Signature	Date

_____	_____	_____
Minors Name	Guardian/Spouse's Signature of Authorizing care for Minor	Date

I hereby authorize Basis Medical, LLC to administer care as deemed necessary to my child, a minor under the age of 18 years old.

EMERGENCY CONTACT

NAME: _____ WORK PHONE: _____

RELATIONSHIP: _____ HOME PHONE: _____

CELL: _____