VANGUARD MEDICAL CENTER

HORMONE CONSULTATION REGISTRATION

711 S. HWY 27, SUITE E
CLERMONT, FL 34711

PHONE: (352) 243-9355
(352) 243-9333

FAX: (352) 243-9334

WEBSITE: *VANGUARDMEDICALCENTER.COM*

Vanguard Medical Center
"Life through Balance"

HORMONE CONSULTATION REGISTRATION

Dear New Client,

On behalf of our staff at Vanguard Medical Center, we welcome to our practice. We look forward to becoming your partner in assessing and improving your health. Our first recommendation is to determine whether the functional medicine path is the right approach for treatment of your health. Functional medicine determines how and why illness occurs and restores health by addressing the root causes of disease for everyone. We believe that by focusing on the cell's health we can prevent disease and/or preserve optimal function of the organs.

Our mission is to provide exceptional quality care to our clients. In order to maintain a mutually beneficial relationship, we have developed our policies and procedures to ensure understanding of our policies and procedures and manage the expectations of our patient population.

What clients can expect from our clinic:

1. The highest level of professionalism and expertise
2. Commitment to individualized care
3. Dedication to the principles of Functional Medicine

What we anticipate from our clientele:

1. Adherence to making and keeping scheduled appointments
2. Diligence in maintaining a healthy lifestyle
3. Respect for our practitioner's expertise and time by:
    a. Paying for all services rendered
    b. Complying to your discussed plan of care
4. Your active participation in keeping us up to date of your current health status and any changes insurance coverage

We believe that misunderstanding and a lack of communication are often the principle obstacle to ensuring continued respect and longevity to a professional relationship. We strive to maintain transparency in our policies and procedures and in return we expect our clients to adhere to them.

Client are required to complete the registration packet in detail, prior to the initial appointment as it needs to be turned in to our office at least 7 days prior the visit. Unfortunately, due to the length of the packet, we will have to reschedule any scheduled appointment as charts needs to be prepared prior to the visits.

Thank you for taking the time to complete this medical questionnaire. The information derived from all of these forms will provide invaluable data in identifying the underlying problems of your health concerns rather than simply treating the symptoms alone.

Welcome to Vanguard Medical Center and we look forward to helping you achieve lifelong health and well-being.

Sincerely,

Frandzie Daphnis MSN, FNP-BC

Vanguard Medical Center ● 711 S Hwy 27, STE E ● Clermont, FL 34711 ● 352-243-9355

Vanguard Medical Center
"Life through Balance"

HORMONE CONSULTATION REGISTRATION

PATIENT INFORMATION: NAME INCLUDING SPELLING MUST MATCH INSURANCE			**DATE: / /**
First Name:	Last Name:	MI:	Date of Birth:
Address:	City:	State:	Zip:
Home Phone: ( ) -	Work Phone: ( ) -	Cell Phone: ( ) -	
E-mail Address:	Other Name(s) Used:	Gender: ☐ M ☐ F	SSN: - -
Preferred Language: ☐ English ☐ Spanish ☐ Other		**Driver's License:** - -	

Marital Status:	**Preferred Contact:**	**Ethnicity:**	**Race:**
☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Life Partner	**Mandatory - May We Leave Confidential Information at This Number**: ☐ Yes ☐ No ☐ Mail ☐ Home Phone ☐ Day Phone ☐ Cell Phone ☐ Patient Portal (Patient Ally)	☐ Cambodian ☐ Filipino ☐ Hispanic/Latino ☐ Non-Hispanic	☐ American Indian or Alaskan Native ☐ Asian Black or African American ☐ Native Hawaiian/Other Pacific ☐ Islander ☐ White Other

Primary Care Provider:	**Referring Provider:**

RESPONSIBLE PARTY (GUARANTOR)			☐ **SAME AS PATIENT**
First Name:	Last Name:	MI:	Date of Birth:
Address:	City:	State:	Zip:
Home Phone: ( ) -	Work Phone: ( ) -	Cell Phone: ( ) -	
E-mail Address:	Other Name(s) Used:	Gender: ☐ M ☐ F	SSN: - -
Preferred Language: ☐ English ☐ Spanish	Driver's License:		

EMERGENCY CONTACT: (FOR MINOR CHILD, THIS SECTION MAY BE USED FOR OTHER PARENT)			
First Name:	Last Name:	MI:	Date of Birth:
Address:	City:	State:	Zip:
Home Phone: ( ) -	Work Phone: ( ) -	Cell Phone: ( ) -	
E-mail Address:	Other Name(s) Used:	Gender: ☐ M ☐ F	
Preferred Language: ☐ English ☐ Spanish			

PRIMARY INSURANCE: PLEASE PRESENT INSURANCE CARDS TO RECEPTIONIST. (MANDATORY FOR LABS IF USING INSURANCE)			
Primary Insurance Name:			
Address:	City:	State:	Zip:
Insurance Phone: ( ) -	Work Fax: ( ) -		
Policy or Prescriber/Subscriber ID #:	**Group#:**		
Relationship to Insured: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER			

SECONDARY INSURANCE:			
Primary Insurance Name:			
Address:	City:	State:	Zip:
Insurance Phone: ( ) -	Work Fax: ( ) -		
Policy or Prescriber/Subscriber ID #:	**Group#:**		
Relationship to Insured: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER			

EMPLOYMENT:			
Employed by:	Occupation:		
Work Address:	City:	State:	Zip:
Work Phone: ( ) -	Work Fax: ( ) -		

PHARMACY OF CHOICE: * MANDATORY *** **			
NAME OF PHARMACY:			
Address:	City:	State:	Zip:
Phone: ( ) -	Fax: ( ) -		

LABORATORY OF CHOICE: (IF DICTATED BY YOUR INSURANCE PROVIDER**)**

☐ LabCorp ☐ Quest Diagnostics ☐ ORHS Hospital (Location)

☐ Advent Health: (Location) ☐ Other: ☐ Other:

ADVANCED DIRECTIVES: **DATE REVIEWED: / /**

☐ None ☐ Do Not Resuscitate ☐ Durable Power of Attorney ☐ Living Will ☐ Health Care Proxy

HOW DID YOU HEAR ABOUT US:

☐ Postcard ☐ Online Search ☐ Search Engine Name: ☐ Google ☐ Bing ☐ Other_____ ☐ Facebook ☐ Twitter

☐ Family or Friend (Please List)_____ ☐ Other _____

Vanguard Medical Center
"Life through Balance"

HORMONE CONSULTATION REGISTRATION
OFFICE POLICIES AND PROCEDURES

Thank you for choosing Vanguard Medical Center. We realize that you have a choice in medical providers and are pleased that you have chosen to seek care with us. Our staff strives to exceed expectations in care and service in order to make your experience with us as comfortable and stress-free as possible. Our office policies help to:

- Prevent misunderstanding and lack of communication.
- Assure uniformity and fairness throughout the practice.

To meet these challenges, the practice reserves the rights, with or without notice, to change, add to or delete any of the policies, terms, conditions and language presented**.**

It is imperative to read all the enclosed information thoroughly and return this registration packet to our office <u>LEAST 7 DAYS</u> prior to your appointment. You may return it to our office by mail, email or fax. *Our system is not interactive, so you will need to print out the documents and then rescan them if you choose to email them to us*.

1. **What We Do:**
   - We are Integrative Medicine Clinic providing clients a root cause analysis of healthcare issues.
   - **We should be considered consultants only.**
   - We consult with clients using **telemedicine** (i.e. phone consultations) so that we may assist clients both locally and across the country.
   - We **DO NOT** provide Primary Care/Family Practice services; therefore, we do not treat chronic diseases such as high blood pressure, diabetes, perform annual physicals, school physicals, etc.
   - Functional medicine focuses on identifying and correcting the root cause of a disease. We utilize professional grade nutraceuticals to nourish the cells thereby improving the health and function of the cells/organ(s)**.**
   - When warranted, we prescribe medication(s) to correct imbalances as well.
   - ***Our customized treatment plans include diets, supplements which are an investment in your health*.**
2. **What to Expect:** ***Initial Here:*** **_____**
   - The frequency of your follow up visits will depend on your chief complaints and the severity of your symptoms. Typically, follow-up visits are usually scheduled in approximately 4–8 weeks from this visit to evaluate progress and make any adjustments in your treatment protocol. Once your condition has stabilized, your visits frequency may be extended to every 10-12 weeks. However, we can make ***no guarantees*** of frequency in visits as it based the condition and response to treatment.
3. **Patient Responsibilities:** ***Initial Here:*** **_____**
   - You are encouraged to ask questions on any health-related topic and to take an active role in your healthcare.
   - We expect our clients to adhere to the plan of care as discussed during the consultations.
   - Failure to follow the plan of care constitutes noncompliance and will result in dismissal from the practice.
   - **IMPORTANT: We ask you to carefully consider your budget before embarking on your healthcare journey to determine if functional medicine is right for you.**
2. **Confidentiality:** ***Initial Here:*** **_____**
   - Information revealed during visits is confidential. Your record and the information contained within it will not be disclosed to others unless you direct us to do so in writing. Exceptions to this confidentiality include disclosure of the intent to harm yourself or others and subpoena from specific government agencies (as outlined in the HIPAA Privacy Rule).
3. **Treatment Plan:** ***Initial Here:*** **_____**
   - Each treatment plan and/or procedure possesses both risks and benefits. You are encouraged to ask questions if you would like additional information.
   - Although your plan will be thoroughly researched and customized to your individual personal goals and health status, no guarantees can be assured regarding the outcomes of treatment plan(s) or procedure(s).
   - **Costs incurred in your treatment plan includes the use of supplements in addition to medications that may be covered by your insurance.**

4. **Communication:** ***Initial Here:*** _____
   - Our staff is well trained in triaging and answering common questions. If there is a need for longer discussion regarding new symptoms or new concerns, we expect clients to schedule an additional follow-up appointment. Questions that require longer than five-minute responses fit this scenario.
   - Our providers **DO NOT** call clients directly as they have scheduled clients back to back during business hours.
   - Should clients experience any medical emergencies, they are expected to seek assistance at the closest Emergency Room (ER) or Urgent Care Center (UCC).
   - Other means of communication include emailing your concerns through our Patient Portal. *Please allow 24 hrs. for a response.*
5. **Emergencies and after-hours care:** ***Initial Here:*** _____
   - **ALL patients are required to have a primary care provider** with whom they can consult in the event of an emergency or urgent problem. **WE OFFER CONSULTATIVE SERVICES ONLY.**
   - Our providers do NOT have hospital affiliations, and do NOT prioritize acute conditions such as infections or injuries.
   - Visits may **ONLY** be scheduled for issues related to a treatment or medication(s) that they have been prescribed.
   - In the event of a medical emergency please do NOT contact our clinic.
   - **Please call your primary care provider or dial 911.**
   - If you notice an adverse effect from one of the components of your Clinic treatment plan, you should discontinue it, then email or call the Clinic during normal business hours.
6. **Insurance:** ***Initial Here:*** _____
   - **Vanguard Medical Center is a self-pay practice ONLY. This means that we are <u>NOT</u> participating providers for ANY INSURANCE PLAN. We are considered OUT OF NETWORK with ALL insurances.**
   - **We <u>CANNOT</u>:**
     - Provide physician referrals to any specialists
     - Complete Prior Authorizations for diagnostic testing
     - Assist with claim resolution
   - If you would like to submit an **out-of-network claim** to your insurance company for reimbursement, or for application towards your deductible, we will provide you with the appropriate and customary codes that reflect the services performed.
   - Please understand that NOT ALL policies reimburse out-of-network claims.
   - We recommend that you inquire with your insurance provider or Human Resource Department to determine whether your plan **has out-of-network benefits** or if you are **subject to an out-of-network deductible or out of network maximum.**
   - An out-of-pocket maximum is the total amount of money you can be required to pay towards your health care before your health insurance policy begins to pay 100% of the costs. This amount differs from plan to plan but usually resets each year. ***There is usually one maximum per person and a higher maximum per family.***
   - A deductible is a set amount of money you are expected to pay before your insurance will start paying for your care. This amount is determined by your specific policy and is set in advance.
   - **<u>WE MAKE NO GUARANTEE OF ANY INSURANCE REIMBURSEMENT.</u>**
   - Typically, a PPO or a POS type plan will have some type of out-of-network coverage, while most HMO and EMO plans only reimburse for out-of-network care in the case of an emergency.
   - **If your insurance will ONLY send payments directly to providers, then you may NOT submit forms for reimbursement as we will NOT accept any payments of these types.**
     - Our services cannot be submitted to these insurances for reimbursement.
   - All fees are settled directly between patient and provider.

- **WE DO NOT TREAT CLIENTS WHO DO NOT HAVE INSURANCE AND CANNOT PAY FOR THE VISITS**.

7. **Financial/Payment:** ***Initial Here:*** _____
   - **Please consider very carefully the cost versus benefit of embarking on Functional Medicine treatments.**
   - **Every client also has a different concept on what is expensive for them and is encouraged to consider the associated cost. *All clients must consider their budgets*.**
   - Our only responsibility rests in devising an individualized plan for the client that will include all needed visits, supplements, labs, imaging, other testing to ensure that progress towards their health goals.
   - **We are not liable for cost incurred during your treatment. While we do our best to recommend cost effective quality treatments, we ask that our client be realistic about their budgets.**
   - Because no two patients are alike so we cannot quote you an exact price for what will be needed for your individual case/condition.
   - <u>All fees are settled directly between patient and provider.</u>
   - We accept **Cash and Credit Cards ONLY**. **WE DO NOT ACCEPT BUSINESS OR PERSONAL CHECKS**.
   - We accept Health Savings Account (HSA) and Flexible Savings Account (FSA) cards. Please check with your card holder or Human Resource department for a full list of eligible medical expenses account holders allowed for their FSA or HSA funds.
   - **Payment is due at the time services are rendered.**
   - **We DO NOT provide refunds or discounts on services provided.**
   - **We DO NOT provide sliding scale or payment plans.**
8. **Credit Cards:** ***Initial Here:*** _____
   - In order to be a client at our facility, a credit card number is required to be on file.
   - This credit card will be used to:
     - To hold all appointments, pay for consultations, supplements, NO CALLS/NO SHOWS.
9. **Auto Accident:** ***Initial Here:*** _____
   - We **DO NOT treat acute injuries** including automobile related injuries.
   - If your injury is a result of an auto accident, you need to seek medical assistance in the emergency room or at an urgent care center.
   - We **DO NOT** bill attorneys for services provided.
10. **Liability Injury:** ***Initial Here:*** _____
    - **We DO NOT treat acute injuries.**
11. **Worker's Compensation:** ***Initial Here:*** _____
    - If your injury is due to an accident in your workplace, please inform the receptionist immediately.
    - **We DO NOT treat acute injuries.**
    - **WE DO NOT treat worker's comp patients.**
    - We are not authorized to treat you for this type of claim. You will need to contact your supervisor for instructions on how to file a worker's compensation claim.
12. **Disability Claims:** ***Initial Here:*** _____
    - We **DO NOT** complete and type of disability forms: **Social Security Disability (SSDI), Supplemental Security Income (SSI), Veterans Disability, Family and Medical Leave Act (FLMA)** programs.
    - These forms should be completed by your Primary Care Provider (PCP).
13. **Legal Issues:** ***Initial Here:*** _____
    - Although we may be sympathetic to your cause, **we are not a party in any pending litigation you may have filed, and we expect payment in full immediately for services.**
14. **Minor Patients:** ***Initial Here:*** _____
    - Unaccompanied minors will be denied non-emergency treatment.

15. Supplementation and Pharmaceuticals: ***Initial Here:*** _____

- All treatment recommendations, including but not limited to supplementation, herbs, peptides, homeopathic remedies and pharmaceuticals should **ALWAYS** be communicated to other providers engaged in your healthcare. **This is required and is the patient's responsibility.**
- Although vitamins, minerals, trace elements, amino acids, herbs, or homeopathic remedies are not classified as drugs. These nutrients have proven to have substantial effects on body's physiology. Our provider(s) offer nutritional guidance and make individualized recommendations regarding use of these substances in order to enhance the quality of foods in a client's diet. Furthermore, supplements deliver nutrition to support the physiological and biomechanical processes of our bodies. Although these products may also be suggested with a specific therapeutic purpose in mind, their usefulness is primarily designed to sustain given aspects of metabolic function.
- Clients are under no obligation to obtain nutritional supplements at our clinic. Access to supplements at our clinic is to ensure convenience and quality of products. We purchase our nutraceuticals directly from from manufacturers who have gained our confidence through considerable research and experience.
- Ultimately our vitamins are purchased through considering: (1) the quality of science behind the product; (2) the quality of the ingredients themselves; (3) the quality of the manufacturing process; and (4) the end results via lab testing and improvement of the patient's health.
- The brands that we recommend meet our high standards while delivering predictable results. While these supplements may come at a higher financial cost than those found on the shelves of pharmacies or health food stores, the value must also include assurance of their purity, quality, bioavailability (ability to be properly absorbed and utilized by the body), and effectiveness.
- **You are not guaranteed the same level of quality when you purchase your supplements from the general marketplace due to potential storage issues (temperature, humidity, etc.).**
- Although we realize that not all products have issue's; often, due to the lack of stringent testing, storage requirements for dietary supplements, product quality varies widely.
- Supplements may be purchased in our office or mailed directly to you.

16. Returns/Refunds ***Initial Here:*** _____

- Supplements (***except for probiotics and protein powders***) may be returned for a refund or exchange **ONLY IF** in **original condition, unopened or unused** within **14 days** of purchase.

17. Specialty Laboratory Testing: ***Initial Here:*** _____

- **Functional Medicine testing and therapies provided by Vanguard Medical Center extend far beyond what traditional insurance will cover, and by them is labeled as "preventative and wellness".**
- Our individualized treatment plans frequently require specialty laboratory testing.
- Some of these tests constitute an out-of-pocket expense for clients.
- Occasionally, there is some insurance coverage. We will guide you through identifying the costs associated with your testing.

18. Laboratory Testing: ***Initial Here:*** _____

- **Uncovering the root cause of the symptom of a condition requires in depth laboratory testing.**
- While we endeavor to order only the necessary testing, but there are many applicable out of pocket expenses (Co-pays, Co-insurances, Deductibles).
- Please remember that it took your body a long time to develop levels of deficit likewise, it will take time, dedication and money to correct the present imbalances.
- Overall, the cost involved is based on the time, energy and expertise invested in you which is heavier on the front end.
- Generally, the results and timeline are heavily influenced by your depth of issues and your level of engagement. (i.e. Your level of compliance to your personalized prescriptive plan weighs heavily on your outcome).

- **All tests billed by the laboratory to your insurance that are not paid by insurance, are your financial responsibility.**
- **Labs that is ordered are subject to the terms and conditions of your health insurance plan, and deductibles or relevant to lab services. This is between your insurance and the lab.**
- **It is your responsibility to know what your insurance benefits are for all test orders (wellness, preventive, etc.).**
- **We encourage our clients to become familiar with all aspects of their insurance coverage before any lab testing takes place.**
- **IMPORTANT:** Please take into consideration your financial situation when embarking on this health journey. If you are unable to invest in your treatment in and out of the office, you may not experience optimal results.
- ALL questions regarding your bill should be directed toward your insurer. Any required testing may be processed via insurance.
- **OUR OFFICE AND PROVIDERS ACCEPT NO LIABILITY FOR ANY TEST NOT COVERED BY YOUR INSURANCE.**
- **If you are unsure of your insurance coverage or whether you have met your deductible, we strongly urge you to contact your insurance company to verify your benefits as well as coverage for the labs ordered.**
- **WE DO NOT PROVIDE PRIOR AUTHORIZATION FOR ORDERED LAB TESTS.**
- We enter your lab orders into our Electronic Medical Record (EMR) which uploads to your laboratory of choice.
- We require all clients to have their labs **drawn at least <u>2 WEEKS</u> prior** to their next scheduled appointment. Failure to do so, will result in a delay in your test results thereby postponing your appointment.
- If you have requested a copy of your orders, they will be sent to you through our patient portal (Patient Ally), **PLEASE DO NOT LOOSE YOUR ORDERS.**
- There are instances when the client will be required to make a follow up appointment (included but limited to the following):
  - ❖ Failure to complete your labs within the allotted time frame
  - ❖ Expiration of the orders: prescriptions, labs, diagnostics, etc. (**The orders are valid for 6 months**)
  - ❖ New concerns or worsening symptoms
  - ❖ Medication issues (Side-effects, etc.)
  - ❖ Need to obtain or change a medicine
  - ❖ Need for a medical (lab, diagnostics test, etc.)
- We **DO NOT** provide **complimentary (free) copies of your lab results**. There is **a <u>$1 per page fee payable at the end of the visit.</u>** *This fee is to defray the printing cost to the practice.* Thank you in advance for your understanding.
- You have the option to use the patient portal for Quest Diagnostics or LabCorp, which is free of charge, to anyone who uses their individual services.

19. Prescriptions and Refills: ***Initial Here:*** **_____**

- **For medical and legal reasons, we ONLY refill prescriptions during office visits.**
- Failure to comply with our policy prevents providers from completing the necessary patient medical assessments, bypassing the opportunity to provide preventive care thereby jeopardizing the patient's safety.
- **Refills are granted <u>ONLY</u> at the time of your appointment.**
- **WE WILL NOT AUTHORIZE REFILLS BY THE PHARMACIES REQUESTED BETWEEN OFFICE VISITS.**
- If you have forgotten to ask for a prescription refill during your visit, our providers MAY only authorize **ONE (1) refill for ONE (1) medication if the request is made within 2 weeks of the office visit.**
- ***If the medication refill request is made after the 2-week deadline has passed, a new appointment will be required.***

- We prescribe enough drugs and refills until your next appointment. **We strongly recommend that clients schedule their next appointment by the end of the consultation.**
- Before your medication runs low, please call us for an appointment.
- ***IT IS YOUR RESPONSIBILITY TO COMPLETE YOUR LAB WORK AND SCHEDULE AN APPOINTMENT FOR FOLLOW UP BEFORE YOU RUN OUT OF MEDICATION.*** ***(This Pertains to Medical and Legal Issues. Client Compliance Is Non-Negotiable in This Area).*** ***Initial Here: _____***
- ***If you are unable to schedule an appointment, we recommend that you go to a walk-in clinic, of your choosing, to obtain a refill. (bring your empty bottle)***
- **ALL PRESCRIPTIONS REFILLS REQUIRE A CONSULTATION**. ***Initial Here: _____***
- **IF PROVIDERS ARE ASKED TO SENT PRESCRIPTION(S) IT MEANS THAT YOU ARE ASKING US TO PERFORM A SERVICE (i.e. Work). It is customary for all business services to be compensated. Please understand that we are a fee for service business that specializes in medicine. We hope that you appreciate the work that we do on your behalf.** *Where most functional medicine practices charge a minimum of $300 per hour, plus a membership fee to be part of the practice, we have tried very hard to keep your cost in an affordable bracket for everyone while maintaining the value to the business.*
- We will **ONLY** refill prescriptions that have originated in this office.
- **ALL prescriptions that are controlled (narcotics, sedative, etc.) will NOT be sent without a visit.**
- We **DO NOT** prescribe controlled substances for chronic conditions - pain, anxiety, insomnia, ADD/ADHD etc..
- We require to you obtain these medications from specialists: pain management providers, psychiatrists, neurologists or PCP.
- **IF YOU ARE OUT OF MEDICATIONS REFILLS, THEN YOU ARE OUT OF COMPLIANCE AND MAY BE DISMISSED FROM THE PRACTICE. (I.E - NO LABS, NO OFFICE VISIT = NO REFILL). THIS IS NON-NEGOTIABLE.**
- We **DO NOT** refill prescriptions after hours.

20. Prior Authorization for Prescriptions: ***Initial Here: _____***

- If your insurance requires a **PRIOR AUTHORIZATION for you to obtain a prescription** from your pharmacy, there will be a **twenty-five ($25) processing fee for this service. Please understand the following:**
  - **This process occurs *outside of the time and cost of your consultation* with the provider(s). *(i.e. This a separate service not covered by your consultation).***
  - **We are a fee for service company. Payment is due at the time the service is rendered.**
- Our office will contact you to alert you of this matter and to collect payment.

21. Pharmacy Prescription Transfer: ***Initial Here: _____***

- For existing prescriptions:
  - Pharmacies must transfer prescriptions with their remaining refills.
- We will **NOT** issue new prescriptions if the prescriptions have refills.
- Please call the pharmacy you which to transfer your prescription to provide them with the necessary information to complete the transfer.

22. Diagnostic Testing and Outside Referrals: ***Initial Here: _____***

- In order to diagnose you, evaluate the effectiveness of a treatment and/or to monitor your health, diagnostic results require a consultation.
- We will review lab and imaging results during a scheduled appointment within 2-3 weeks following your current visit or as your results become available.
- Please remember that this is a service that we provide for all our clients to sustain your optimal health. Payment is due at the time services are rendered.

23. Form Completion: ***Initial Here*:_____**

- Vanguard Medical Center requires payment for the completion of forms/letter(s) any patient asks us to complete on their behalf.

- ***Forms are never completed during the consultation with the provider.***
- Expected time frame for form completion is minimum of **10 – 14 business days** from the time of registration; however, we **cannot make any assurance of completion with the patient's time frame(s).**
- Payment is required prior to completion of all forms/letters.
- There is a flat rate **fee at $25.00** for completion of most forms/letters. Payment is due at the time forms are dropped off at the office. An **extra $35.00** is applied **for the rush/urgent completion of the forms/letters**.
- We reserve the right to charge additional fees for forms **greater than 5 pages**.
- We accept cash or credit cards **ONLY**.

24. Missed and Cancellation of Appointments: ***Initial Here:*** _____

- **In order to be respectful of the medical needs of other patients, please be courteous and call our office promptly if you are unable to show up for an appointment. This time will be reallocated to someone who needs treatment.**
- **IF IT IS NECESSARY TO CANCEL YOUR SCHEDULED APPOINTMENT, WE REQUIRE THAT YOU CALL AT LEAST 72 HOURS (3 BUSINESS DAYS) IN ADVANCE.**
- **THIS MUST BE FROM YOUR APPOINTMENT TIME. (I.E TUESDAY 9:00 AM APPOINTMENT SHOULD BE CANCELLED NO LATER THAN MONDAY 9:00 AM OR BEFORE).**
- **APPOINTMENTS ARE IN HIGH DEMAND, AND YOUR EARLY CANCELLATION WILL ALLOW ANOTHER PATIENT ACCESS TO TIMELY MEDICAL CARE.**
- **Acceptable notification must be received during business hours of operations of Vanguard Medical Center.**
  - **To cancel a Thursday appointment, please call our office by 1:00 p.m. on Monday.**
  - **Office Hours: Monday, Tuesday and Thursday 8:30 AM – 4:30 PM. Wednesday 9:00 AM – 3 PM. Closed on Fridays.**
- **Failure to Call Our Office During Business Hours 72 Hours (3 Business Days) Prior to Your Scheduled Appointment to Reschedule or Cancel Will Result in a Cancellation Fee. $100 PER MISSED VISIT**

PAYMENT IS THE SOLE RESPONSIBILITY OF THE CLIENT

- **Late cancellations**
  - ***(A CANCELLATION IS CONSIDERED TO BE LATE WHEN THE APPOINTMENT IS CANCELLED WITHOUT A 72-HOUR (3 BUSINESS DAYS) ADVANCE NOTICE) WILL BE CONSIDERED AS A "NO-SHOW" AND WILL BE SUBJECT TO THE CANCELLATION FEE.***
- **THREE (3) MISSED APPOINTMENTS WITHOUT PRIOR NOTIFICATION, WILL RESULT IN THE IMMEDIATE DISMISSAL FROM OUR PRACTICE.**
- **If you are a new patient who does not show up or does not call to cancel your appointment, you will not be allowed to make any further appointments.**

25. Late Arrival Appointments: ***Initial Here:*** _____

- We are committed to being on time with patients' appointments in order to prevent clients from waiting.
- If you are tardy **15 minutes or greater** for your appointment, we will need to reschedule your appointment.
- If you arrive **10 minutes** late for your consult your appointment will end at the scheduled time and you will be charged for the length of the originally scheduled visit.

26. Other Policies ***Initial Here:*** _____

- **IF YOU HAVE NOT VISITED THE CLINIC IN GREATER THAN 1 YEAR, YOU WILL NO LONGER BE CONSIDERED AN ACTIVE PATIENT.**
- We **DO NOT** allow the re-establishment of a patient once they have transferred care to another provider for any reason other than relocation.

27. Medical Records for Personal Use: ***Initial Here:*** _____

- If you need printed copies of your medical records for your personal use, **we will require a minimum of two-week notice**.

- There will be a charge of **$1.00 per page.** *This fee is to defray the printing cost to the practice*.
- If you are transferring your care to a new clinic or provider, please complete a release of records at the new provider's office and we will forward your records to them within the allotted time.
- There will be no charge for medical records if another provider or medical facility is requesting your records.
- Please **DO NOT** request your medical records be faxed, from another provider, **PRIOR** to your initial appointment. The provider will decide when and if there is a need for your medical records.

28. Affordable Care Act Mandates Updates: ***Initial Here:*** _____

- Please note that all prescription refills, lab orders, radiology orders (x-ray, mammogram, etc.), and referrals **MUST** be accompanied by a consultation.
- **We Do Not Write Prescriptions Without A Consultation. There Will Be No Exceptions.**
- **If You Allow Your Lab or Radiology Orders to Expire, You Will Be Required to Schedule an Appointment To Obtain New Orders.**
- **ALL PRESCRIPTIONS REQUIRE A FOLLOW UP APPOINTMENT EVERY 3 TO 6 MONTHS.**
- These changes are due to the new restrictions within the Affordable Care Act which are designed to reduce insurance and identity fraud in medical procedures, and, as these are Federal laws, cannot be changed or broken by anyone in our office. Even though we do not take insurance, we abide by these guidelines.
- To help us, please have your medications, list of supplements to handy at **EVERY** appointment.

PLEASE INITIAL EACH BLANK SPACE BELOW:

****IF YOU ARE HELD RESPONSIBLE FOR ABIDING BY THESE POLICY EVEN IF YOU CHOOSE NOT TO SIGN OR INITIAL ****

_____ I agree to promptly pay for the services rendered for me or the patient named above. If I fail to meet my financial commitment and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account, including attorney and collection agency fees.

_____ I further agree to pay for any missed appointments of which I did not notify the medical office within **72 HOURS (3 Business Days)** of the scheduled time.

_____ I authorize to test my blood for hepatitis and/or the AIDS virus, if in their opinion; an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration.

I have read and understand the ALL office policies of Vanguard Medical Center, LLC. By my signature I agree to the terms outlined and will endeavor to abide by the policies and procedures of the practice.

_____ _____ - _____ - _____

Signature of Patient/Responsible Party ***Date***

_____ _____

Name of Patient/Responsible Party (Please Print) ***Relationship to Patient***

Vanguard Medical Center
"Life through Balance"

HORMONE CONSULTATION REGISTRATION

CREDIT CARD AUTHORIZATION FORM

1. ***Initial Here:*** _____ In order to provide you and other patients of Vanguard Medical Center the best possible care**,** **a minimum of 72 hours' notice** is required to cancel or reschedule your appointments.
2. I, _____, understand the importance of notifying the office at least **72 hours** prior to my scheduled appointment that I am not able to keep my appointment.
3. ***Initial Here:*** _____ I understand that same day cancellations are considered No Call/No Show and will subject to the **$100** No Call/No Show fee. **I UNDERSTAND THAT THE PRACTICE DOES NOT NEED TO CONTACT PRIOR TO PROCESSING PAYMENT IN THIS INSTANCE.**
4. ***Initial Here:*** _____ I understand that I will be charged a No Call/No Show fee of **$100** for failing to call and failing to show for my scheduled appointment.
5. I, _____, give Vanguard Medical Center, the authorization to charge my credit Card.
6. ***Initial Here:*** _____ I understand that this credit card can be used for vitamin/supplement purchases if I so choose. The final cost for the purchase shall be provided to me **PRIOR** to processing the card.
7. ***Initial Here:*** _____ I will be provided a receipt for all payments **upon request**.
8. ***Initial Here:*** _____ I understand that I may revoke this agreement at any time by providing a **request in writing**.
9. ***Initial Here:*** _____ I am also aware that when I am no longer a client of Vanguard Medical Center, this form shall be shredded once I am terminated from treatment.

COMMON FAQ'S

1. **What about identity theft and privacy?**
   Under HIPPA, we are under strict rules and guidelines in terms of protecting patient privacy and the credit card is considered protected health information. Because of HIPPA rules, our medical office is far more secure than most retail establishments as it relates to identity theft.
2. **This is not the same as "signing a blank check"?**
   What we are doing is nothing different than what a hotel or rental car company does at each check in. All credit card contracts give cardholders the right to challenge any charge against their accounts.
3. **I don't have a credit card.**
   You are welcome to leave a HSA (Health Savings Account), Flex Plan or Debit card on file or pay with cash or check for the visit in full. We understand there are legitimate reasons you might not have a card (declared bankruptcy, maxed out, or declared unworthy of credit). If this is the case, we will work out a payment plan with you.

This card will only be authorized for the use of the credit card holder or any person(s) listed below by the credit card holder. This agreement will expire upon termination of services and settlement of final balance. The card holder may also revoke this consent at any time in writing while understanding that continued services may not be available if an unpaid balance accrues.

☐ **Visa** ☐ **MasterCard** ☐ **Discover** ☐ **American Express**

Credit Card Holder's Name: _____ **Expiration Date:** ____/____/____ (Please Print)

Credit Card # _____ **Billing Zip Code:** _____

CVV# (on back of card): _____

Please fill out the information below for any other person(s) you authorize this credit card for: ***IF NO OTHERS ALLOWED, STRIKE THROUGH BELOW AND INITIAL.***

Patient Full Name: _____ DOB: ____/____/____

Patient Full Name: _____ DOB: ____/____/____

Patient Full Name: _____ DOB: ____/____/____

Credit Card Holder's Signature: _____ Date: ____/____/____

HORMONE CONSULTATION REGISTRATION

GENERAL CONSENT AND RIGHT TO REFUSE TREATMENT

GENERAL CONSENT TO TREATMENT:

I,_____(or my authorized representative on my behalf) by signing below, authorize **Vanguard Medical Center** and its staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries.

I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

RIGHT TO REFUSE TREATMENT:

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

I understand that routine health care is confidential and voluntary and may involve provider office visits which include history taking, examinations, administration of medications, laboratory tests, and/or minor procedures. I understand that I may discontinue services at any time.

_____ _____ - _____ - _____

Signature of Patient/Responsible Party ***Date***

_____ _____

Name of Patient/Responsible Party (Please Print) ***Relationship to Patient***

HORMONE CONSULTATION REGISTRATION

NOTICE OF PRIVACY PRACTICES

Revised Date: September 23, 2015

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. IF YOU WISH TO REQUEST A DETAILED VERSION OF THIS PRIVACY PRACTICE NOTICE, PLEASE CONTACT THE PRIVACY OFFICER OR VIEW THE FORM ON OUR WEBSITE AT WWW.VANGUARDMEDICALCENTER.COM

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.
This facility will abide by the terms presented within this Notice. For any uses or disclosures that are not listed below (Including Marketing and Selling of PHI), the Facility will obtain a written authorization from you for that use or disclosure, which you will have the right to revoke at any time, as explained in more detail below. **The Facility reserves the right to change the Facility's privacy practices and this Notice**

Uses and Disclosures: We may use and disclose your protected health information (PHI) in the following ways:

- ✓ For purposes of treatment, payment, and hospital operations.
- ✓ When release is required by law, including: for military purposes, for law enforcement requests, for national security reasons, or for healthcare regulatory or accrediting agencies.
- ✓ In emergency situations or for health and safety reasons.
- ✓ To medical examiners, coroners, or funeral directors.
- ✓ To organ, tissue, and other donation organizations.
- ✓ To contact you about appointment reminders or to tell you about other health-related benefits and services.
- ✓ For our directory.
- ✓ For Worker's Compensation requests.
- ✓ To people who are involved in your care.
- ✓ For other purposes as set forth in the full Notice of Privacy Practices.

All other uses and disclosures by Vanguard Medical Center will require us to obtain from you a written authorization.

YOUR RIGHTS:

- ✓ **Restrictions:** To ask us to limit the information we share, including a right to not have your information disclosed to your health plan when you pay for your services yourself. We will consider requests on an individual basis.
- ✓ **Confidential communications:** To receive your confidential health information by alternate addresses, telephone numbers, or fax numbers.
- ✓ **Access:** To inspect or receive copies of your medical record (**Fee required**).
- ✓ **Amendments:** To request changes be made to your health information. (The request will be considered on an individual basis).
- ✓ **Accounting:** To receive a list of our disclosures of your health information.
- ✓ **This notice:** To ask for a copy of our full privacy notice.
- ✓ **Complaints:** If you feel your privacy rights have been violated, please contact the hospital departments listed below to file a complaint with the hospital. You may also complain to U.S. Department of Health & Human Services Office of Civil Rights. You will not be retaliated against for filing a complaint.

Our Duties: We are required by law to maintain the privacy of your PHI. We must abide by the terms of this notice or any update of this notice. Updates to this notice are effective for all PHI we maintain. We must provide notification to you of a breach of unsecured PHI.

REVISIONS TO THE NOTICE OF PRIVACY PRACTICES

The Facility reserves the right to change and/or revise this Notice and make the new revised version applicable to all PHI received prior to its effective date. The Facility will also post the revised version of the Notice in the Facility.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Facility and/or to the Secretary of HHS, or his designee. If you wish to file a complaint with the Facility, please contact FRANDZIE DAPHNIS, MSN, FNP-BC, if you wish to file a complaint with the Secretary, please write to: *http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html*

CONTACT INFORMATION

If you have any questions or for clarification on anything contained within this notice, please contact Frandzie Daphnis, MSN, FNP-BC – Vanguard Medical Center Privacy Officer at (352) 243-9355 711 S. Hwy 27, Suite E, Clermont, FL 34711.

I acknowledge that I have had an opportunity to review the Notice of Privacy Practices.

_____ _____ - _____ - _____

Signature of Patient/Responsible Party ***Date***

_____ _____

Name of Patient/Responsible Party (Please Print) ***Relationship to Patient***

Vanguard Medical Center
"Life through Balance"

HORMONE CONSULTATION REGISTRATION

PATIENT INFORMATION RELEASE INFORMATION AUTHORIZATION FAMILY AND SIGNIFICANT OTHERS

I understand that by signing this authorization form, at my request, I authorize Vanguard Medical Center and its provider to release specific information to the following individuals:

1. _____ **Relationship:**_____ **Phone:** (_____)_____-_____

2. _____ **Relationship:**_____ **Phone:** (_____)_____-_____

I understand that my alcohol and/or drug treatment records are protected under both the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996
("HIPAA"), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written permission unless otherwise provided for in the regulations. My other treatment records are protected under HIPAA. I also understand that I may cancel this consent in writing at any time except when the release of information has occurred, and that this consent expires automatically as follows:

- The purpose for which it was obtained has occurred, or
- It has been 6 or more days since my discharge from a program of this clinic, whichever is later.

The specific purpose and need for this disclosure is to help arrange for and establish treatment.

☐ Treatment dates, History, Progress, Recommendations, Admissions, Medications and Discharge Plans
☐ Diagnosis and Prognosis which may include acquired immunodeficiency syndrome (AIDS), AIDS-related complex (ARC), human immunodeficiency virus (HIV)
☐ Sexually Transmitted Diseases (STDs)

RE-USE OF INFORMATION:

I understand that if I authorize the release of my health information to someone who is not legally required to keep it confidential, that information may be shared with others and may no longer be protected. I also understand that under no circumstances am I required to authorize the release of psychotherapy notes.

CONDITIONS:

I understand that I do not have to sign this Authorization form. I understand that treatment, payment, enrollment and eligibility for benefits will not be based on my signing or refusing to sign this authorization, except if treatment is related to research, or if health care services are given to me only for creating protected health information for release to a third party.

RIGHT TO TAKE BACK AUTHORIZATION:

I understand that I have the right to take back my authorization. If I take back my authorization**, I have to notify the Vanguard Medical in writing, I have to sign the notice, and I have to deliver the notice** at the following address: Vanguard Medical Center, 711 S. Hwy 27, Suite E, Clermont, FL 34711. The notice will be in effect when received by the Vanguard Medical. Any information already shared by this authorization cannot be taken back.

EXPIRATION:

This authorization will go into effect immediately and will remain in effect until_____(write in date).
If I do not write in a date, this authorization will remain in effect for one year from the date of my signature.

I have read and understand the financial policies of Vanguard Medical Center, LLC. By my signature I agree to the terms outlined in the financial policies.

_____ _____ - _____ - _____

Signature of Patient/Responsible Party ***Date***

_____ _____

Name of Patient/Responsible Party (Please Print) ***Relationship to Patient***

Vanguard Medical Center
"Life through Balance"

HORMONE CONSULTATION REGISTRATION

PATIENT EDUCATION INFORMATION AND HORMONE REPLACEMENT THERAPY INFORMED CONSENT

I, the undersigned, authorize and give my Informed Consent to Vanguard Medical Center for the administration of Bio-Identical hormone replacement therapy.

1. **Expected Benefits of Hormone Replacement Therapy**
   - ✓ Expected benefits include control of symptoms associated with declining hormone levels.
   - ✓ Possible benefits of this therapy may help prevent, reduce or control physical diseases and dysfunction associated with declining hormone levels, through hormonal replacement.
   - ✓ I have been fully informed, and I am satisfied with my understanding, that this treatment may be viewed by the medical community as new, controversial, and unnecessary by the Food and Drug Administration.
   - ✓ I understand that my healthcare provider cannot guarantee any health benefits or that there will be no harm from the use of hormone replacement therapy

2. **Risks and Side Effects of Hormone Replacement Therapy**

   Some of the following risks/adverse reactions are derived from the official Food and Drug Administration "FDA" labeling requirements for these drugs, for therapeutic drug levels in the blood stream. My healthcare provider may prescribe these medications at dosages designed to achieve physiologic levels of hormones in my blood stream or urine generally associated with those of a 20-35 year-old person and would be within the "normal" or "average" blood concentrations of that age group.

   a. General (**PLEASE INITIAL EACH LINE**)

   _____ I understand that the general risks of this proposed therapy may include, but are not limited to, bruising, soreness or pain, and possible infection for hormones administered by injection.

   _____ I understand that there are risks (both known and unknown) to any medical procedure, treatment and therapy, and that it is not possible to guarantee or give assurance of a successful result. I acknowledge and accept these known and unknown general risks.

   _____ I certify that I have been given the opportunity to ask any and all questions I have concerning the proposed treatment, and I received all requested information and all questions were answered. I fully understand that I have the right to not consent to hormone replacement therapy. I believe I have adequate knowledge upon which to base an informed consent.

4. **Prescriptions**
   - Hormone therapy prescriptions will be written to provide you with enough refills until your next scheduled office visit. If you are unable to come to your scheduled visit due to unforeseen circumstances or are overdue for blood work (necessary for monitoring the safety or effectiveness of a medication), the provider may agree to call in a **ONE (1) month** refill to the pharmacy, (if deemed medically appropriate) to allow you to re-schedule the missed appointment. (***Refills are at the sole discretion of the provider***)
   - **IF THIS RE-SCHEDULED VISIT IS MISSED AND/ OR THE REQUIRED BLOOD WORK IS NOT OBTAINED, WE WILL BE UNABLE TO ISSUE ANY FURTHER REFILLS UNTIL THE ABOVE REQUIREMENTS ARE MET.**

5. **Physical Exams**
   - Annual physical exams with prostate/rectal exam (males) or with GYN exam (females) are **required by our office if we are prescribing your hormones even if you have had an exam done with your primary care physician or specialist**. This is done for your safety and in compliance with standards set by medical boards.
   - **IMPORTANT:** ***WE HAVE THE RIGHT TO REFUSE TO PROVIDE BHRT REFILLS IF THIS INFORMATION IF NOT UP TO DATE IN YOUR RECORDS.***
     - **FEMALE CLIENTS:** Please ensure that you forward the results of your WWE exam, including pap test, mammogram, pelvic transvaginal result (if applicable) **To Vanguard Medical Cente**r when performed elsewhere.
     - **THIS IS REQUIRED ANNUALLY IF YOU ARE BEING TREATED WITH THE USE OF BHRT BY OUR PROVIDERS.**
     - **MALE CLIENTS:** Please ensure that you forward the results of your if prostate/rectal exam (if applicable) to vanguard medical center when performed elsewhere.

6. ***Male patients on testosterone***
   - ✓ Testosterone, PSA, Estradiol and CBC levels are monitored every **4 - 6 months** (or sooner if medically necessary).
   - ✓ **Please check with your insurance if they will cover the cost of these tests since some insurance plans may only cover PSA levels once a year.**

7. ***Female patients on Hormones***
   - ✓ Estrogens (Estradiol, Estrone, Estriol) Progesterone and Testosterone levels are monitored every **3-6 months** (or sooner if medically necessary)
   - ✓ **Please check with your insurance if they will cover the cost of these tests since some insurance plans may only cover them once a year.**

I do now attest to reading and fully understanding this form, the contents and clinical meanings of such, and discussing these procedures with my healthcare provider and consent to this treatment, and hereby affix my signature to this authorization for this proposed long-term treatment. I have been given a copy of this consent form, and I understand fully any and all of the possibly represented implications and meanings of its writing and expectations. ***If you have any questions as to the risks and benefits of the proposed treatment or any questions concerning the proposed treatment, ask your healthcare provider now before signing this consent form. Please Do Not sign unless you have read and thoroughly understand this form.***

_____ _____ _____ - _____ - _____

Signature of Patient/Responsible Party ***Name of Patient/Responsible Party (Print)*** ***Date***

Vanguard Medical Center
"Life through Balance"

HORMONE CONSULTATION REGISTRATION

NOTICE OF PRIVACY PRACTICES

Revised Date: September 23, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact Frandzie Daphnis – Vanguard Medical Center Privacy Officer at (352) 243-9355 711 S. Hwy 27, Suite E Clermont, FL 34711.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other personnel.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about you, your health, health status, and the health care and services you receive from **Vanguard Medical Center LLC**. Your health information may include information created and received by **Vanguard Medical Center LLC**, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose health information for the following purposes:

• **For Treatment**. We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, staff or other personnel who are involved in taking care of you and your health.

Different personnel in our organization may share information about you and disclose information to people who do not work for Vanguard Medical Center LLC in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have. We will request your permission before sharing health information with your family or friends unless you are unable to give permission to such disclosures due to your health condition.

• **For Payment**. We may use and disclose health information about you so that the treatment and services you receive at Vanguard Medical Center LLC may be billed to and payment may be collected from you, an insurance company or a third party.

For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will pay for the treatment.

• **For Health Care Operations**. We may use and disclose health information about you in order to run Vanguard Medical Center LLC and make sure that you and our other patients receive quality care.

For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

We may also disclose your health information to health plans that provide you insurance coverage and other health care providers that care for you. Our disclosures of your health information to plans and other providers may be for the purpose of helping these plans and providers provide or improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law.

SPECIAL SITUATIONS

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

• **To Avert a Serious Threat to Health or Safety**. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

• **Required By Law**. We will disclose health information about you when required to do so by federal, state or local law.

• **Research**. We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

• **Organ and Tissue Donation**. If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

• **Military, Veterans, National Security and Intelligence**. If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

• **Workers' Compensation**. We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

• **Public Health Risks**. We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

• **Organ and Tissue Donation.** If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

• **Military, Veterans, National Security and Intelligence.** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

• **Workers' Compensation.** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

• **Public Health Risks.** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

• **Health Oversight Activities.** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

HORMONE CONSULTATION REGISTRATION

NOTICE OF PRIVACY PRACTICES

• **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.
• **Law Enforcement.** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.
• **Coroners, Medical Examiners and Funeral Directors.** We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.
• **Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
• **Family and Friends.** We may disclose health information about you to your family members or friends **if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection**. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room or the hospital during treatment or while treatment is discussed.
In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. Examples of disclosures requiring your authorization include disclosures to your partner, your spouse, your children and your legal counsel.
We also will not use or disclose your health information for the following purposes without your specific, written Authorization:
• ***For our marketing purposes.*** *This does not including face-to-face communication about products or services that may be of benefit to you and about prescriptions you have already been prescribed.*
• ***For the purpose of selling your health information.*** *We may receive payment for sharing your information for, as an example, public health purposes, research, and releases to you or others you authorize a release to as long as* payment is reasonable and related to the cost of providing your health information.

• **Any disclosure of your psychotherapy notes.** These are the notes that your behavioral health provider maintains that record your appointments with your provider and are not stored with your medical record.
If you give us Authorization to use or disclose health information about you, you may revoke that Authorization, **in writing,** at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.
In some instances, we may need specific, written authorization from you in order to disclose certain types of specially-protected information such as psychotherapy notes, HIV, substance abuse, mental health, and genetic testing information for purposes such as treatment, payment and healthcare operations.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT

Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.
We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:
• **Right to Inspect and Copy.** You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to *Vanguard Medical Center's Privacy Officer* in order to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. A modified request may include requesting a summary of your medical record.
If you request to view a copy of your health information, we will not charge you for inspecting your health information. If you wish to inspect your health information, please submit your request to the *Vanguard Medical Center's Privacy Officer* in order to inspect and/or copy records of your health information. If you request a copy of the information, we will charge a fee for the costs of copying, mailing or other associated supplies. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. A modified request may include requesting a summary of your medical record.
We may deny your request to inspect and/or copy your record or parts of your record in certain limited circumstances. If you are denied copies of or access to, health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

HORMONE CONSULTATION REGISTRATION

NOTICE OF PRIVACY PRACTICES

• **Right to Amend.** If you believe health information, we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment if the information is kept by *Vanguard Medical Center.*
To request an amendment, complete and submit a medical record amendment/correction form to Vanguard Medical Center Privacy Officer.
We may deny your request for an amendment if your request is not in writing or does not include a reason to support the request. In addition, we **may deny** or partially deny your request if you ask us to amend information that:
• We did not create, unless the person or entity that created the information is no longer available to make the amendment
• Is not part of the health information that we keep
• You would not be permitted to inspect and copy
• Is NOT accurate and/or complete
If we deny or partially deny your request for amendment, you have the right to submit a rebuttal and request the rebuttal be made a part of your medical record. Your rebuttal needs to be *(number)* of pages in length or less and we have the right to file a rebuttal responding to yours in your medical record. You also have the right to request that all documents associated with the amendment request (including rebuttal) be transmitted to any other party any time that portion of the medical record is disclosed.
• **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment, health care operations, when specifically authorized by you and a limited number of special circumstances involving national security, correctional institutions and law enforcement.
To obtain this list, you must submit your request in writing to Vanguard Medical Center Privacy Officer. It must state a time period, which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we will charge you for the costs of providing the list. You may withdraw or modify your request at that time before any costs are incurred.
• **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.
We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or we are required by law to use or disclose the information.
We are required to agree to your request *if you pay for treatment, services, supplies and prescriptions "out of pocket" and you request the information not be communicated to your health plan for payment or health care operations purposes.*
There may be instances where we are required to release this information if required by law.
To request restrictions, you may complete and submit the Request for Restriction on Use/Disclosure of Medical Information to Vanguard Medical Center Privacy Officer.

• **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.
To request confidential communications, you may complete and submit the Request for Restriction on Use/Disclosure Of Medical Information and/or Confidential Communication to Vanguard Medical Center's Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
• **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. [You may also find a copy of this Notice on our web site.]
To obtain such a copy, contact Vanguard Medical Center's Privacy Officer.

CHANGES TO THIS NOTICE
We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. {If a direct care provider - We will post the current notice at our location(s) with its effective date in the top right-hand corner. You are entitled to a copy of the notice currently in effect.

Vanguard Medical Center
"Life through Balance"

HORMONE CONSULTATION REGISTRATION

COMPREHENSIVE MEDICAL QUESTIONNAIRE

Briefly Describe Your Top 3 Complaints/Symptoms or Reason for Your Appointment: (PLEASE DO NOT LEAVE BLANK)

1. _____
2. _____
3. _____

Thank you for choosing our office to assist you with your health care. Our ability to draw effective conclusions about your state of health and how to optimize its improvement depends largely on the accuracy of the information in which you provide, including symptoms that you may consider minor. Health issues may be influenced by many factors; therefore, ***it is important that you carefully consider the questions asked in this form as well as those posed by the provider during your consultation.***

This will assist our goal to provide you with an optimal plan of health care, enhance our efficiency, and will provide effective use of your scheduled time.

What are your health goals for the next year? _____
Where were you getting your care before? _____

REVIEW OF SYMPTOMS: Please mark the box and/or circle any persistent symptoms you have had in the past few months. Read through every section and check "**no problems**" if none of the symptoms apply to you.

General
☐ Unexplained weight loss / gain
☐ Unexplained fatigue / weakness
☐ Fall asleep during day when sitting
☐ Fever, chills
☐ **No problems**

Skin
☐ New or change in mole
☐ Rash / itching
☐ **No problems**

Breast
☐ Breast lump / pain / nipple discharge
☐ **No problems**

Ears/Nose/Throat
☐ Nosebleeds, trouble swallowing
☐ Frequent sore throat, hoarseness
☐ Hearing loss / ringing in ears
☐ **No problems**

Eyes
☐ Change in vision / eye pain / redness
☐ **No problems**

Cardiovascular
☐ Chest pain / discomfort
☐ Palpitations (fast or irregular heartbeat)
☐ **No problems**

Respiratory
☐ Cough / wheeze
☐ Loud snoring / altered breathing during sleep
☐ Short of breath with exertion
☐ **No problems**

Gastrointestinal
☐ Heartburn / reflux / indigestion
☐ Blood or change in bowel movement
☐ Constipation
☐ **No problems**

Genitourinary
☐ Leaking urine
☐ Blood in urine
☐ Nighttime urination or increased frequency
☐ Discharge: penis or vagina
☐ Concern with sexual function
☐ **No problems**

Musculoskeletal
☐ Neck pain
☐ Back pain
☐ Muscle / joint pain
☐ **No problems**

Endocrine
☐ Heat or cold sensitivity
☐ **No problems**

Hematologic/Lymphatic
☐ Swollen glands
☐ Easy bruising
☐ **No problems**

Neurological
☐ Headache
☐ Memory loss
☐ Fainting
☐ Dizziness
☐ Numbness / tingling
☐ Unsteady gait
☐ Frequent falls
☐ **No problems**

Allergic/Immune
☐ Hay fever / allergies
☐ Frequent infections
☐ **No problems**

Psychiatric
☐ Anxiety / stress / irritability
☐ Sleep problem
☐ Lack of concentration
☐ **No problems**

Women only
☐ Pre-menstrual symptoms (bloating cramps, irritability)
☐ Problem with menstrual periods
☐ Hot flashes / night sweats
☐ **No problems**

Men only
☐ Erectile Dysfunction
☐ Impotence
☐ Loss of muscle mass, tone, or strength
☐ Problems with urination (decreased stream, frequent night urination)
☐ **No problems**

IMPORTANT PLEASE COMPLETE: NECESSARY FOR PRESCRIPTIONS

HT _____ ft. _____ in WT ____LBS
RECENT ☐ WEIGHT GAIN:_____# TIME FRAME: _____ RECENT ☐ WEIGHT LOSS:_____# TIME FRAME: _____

IMMUNIZATIONS: Check off any vaccinations you have had. **Add year**, if known. Check the box ONLY if you don't remember the dates.

☐ Hepatitis A _____ ☐ Hepatitis B _____ ☐ HPV _____ ☐ Influenza (flu shot) _____ ☐ Meningitis _____
☐ MMR _____ ☐ Pneumovax (pneumonia) _____ ☐ Tetanus (Td) _____
☐ Varicella (Chicken Pox) shot or illness _____ ☐ With Pertussis (Tdap) _____ ☐ Zostavax (shingles) _____

Vanguard Medical Center
"Life through Balance"

HORMONE CONSULTATION REGISTRATION

COMREHENSIVE MEDICAL QUESTIONNAIRE

ALLERGIES: ☐ **No Known Drug Allergies**

	Allergy	Reaction	Date
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

MEDICATION: PRESCRIPTIONS. Please list **all** prescriptions birth control pills, herbs, inhalers, etc. Use the back of this form if you need more room and let us know you wrote there. ☐ **Take No Medications**

	Name	Dosage (Milligrams) & How Often Per Day	Reason Prescribed
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____

MEDICATION: OVER THE COUNTER SUPPLEMENTS/VITAMINS OR MEDICATIONS. Please list **all** non-prescription medications, vitamins, home remedies, herbs, etc. ☐ **Take No Medications**

	Name	Dosage (Milligrams) & How Often Per Day	Reason Taken
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

HEALTH MAINTENANCE SCREENING TESTS:

Test	***Date***	***Abnormal***	***Comment***
Blood Tests (including blood sugar)		☐ Yes ☐ No	
Lipid (cholesterol)		☐ Yes ☐ No	
Complete Physical Exam		☐ Yes ☐ No	
Sigmoidoscopy or Colonoscopy (circle one)		Polyp ☐ Yes ☐ No	
Bone Density Test		☐ Yes ☐ No	
EKG		☐ Yes ☐ No	
Ultrasound: (Type_____)		☐ Yes ☐ No	
CAT Scan (Type _____)		☐ Yes ☐ No	
Women only:			
Mammogram		☐ Yes ☐ No	
Pap Smear		☐ Yes ☐ No	
Clinical Breast Exam		☐ Yes ☐ No	
Other:			
Men only:			
PSA		☐ Yes ☐ No	
Last Digital Prostate Exam		☐ Yes ☐ No	
Other:			

Vanguard Medical Center
"Life through Balance"

HORMONE CONSULTATION REGISTRATION

PERSONAL MEDICAL HISTORY: Do you have now (current) or have you had (past) any of the following conditions?

☐ **None**

Condition	*Code*	*Current*	*Past*	*Comments*
Allergy (Hay Fever)	477.9			
Anemia	285.9			
Anxiety	300.00			
Arthritis (Rheumatoid)	714.0			
Arthritis (Osteoarthritis)	715.90			
Asthma	493.90			
Bladder / Kidney Problems				
Blood Clot (leg)	453.40			
Blood Clot (lung)	415.11			
Blood Transfusion	V58.2			
Breast Lump (benign)	611.72			
Cancer Breast	174.9			
Cancer Colon	153.9			
Cancer Other Type				
Cancer Ovarian	183.0			
Cancer Prostate	185			
Cataracts	366.9			
Chicken Pox	052.9			
Colon Polyp	211.3			
Coronary Artery Disease	414.00			
Depression	311			
Diabetes (adult onset)	250.00			
Diabetes (childhood onset)	250.01			
Diverticulosis	562.10			
Emphysema	492.8			
Fractures (broken bones)	**Where?**			
Gallbladder Disease	574.20			
Gastroesophageal Reflux (Heartburn/GERD)	530.81			
Glaucoma	365.9			
Gout	274.9			
Gynecological Conditions (Endometriosis)	617.9			
Gynecological Conditions (Fibroids)	218.9			
Gynecological Conditions (Other)				
Heart Attack	410.90			
Hepatitis – Type A	070.1			
Hepatitis – Type B	070.30			
Hepatitis – Type C	070.51			
Hepatitis – Other	070.59			
High Blood Pressure	401.9			
High Cholesterol	272.0			
Hip Fracture	820.8			
Irritable Bowel Syndrome	564.1			
Kidney Disease / Failure	586			
Kidney Stones	592.0			
Liver Disease	573.9			
Migraine Headaches	346.90			
Osteoporosis	733.00			
Pneumonia	486			
Prostate (enlargement)	600.00			
Prostate (nodules)	600.10			
Other (list):				
Other (list):				
Other (list):				
Other (list):				
Other (list):				
Other (list):				

HORMONE CONSULTATION REGISTRATION

Condition	*Code*	*Current*	*Past*	*Comments*
Seizure / Epilepsy	780.39			
Skin Condition (Eczema)	692.9			
Skin Condition (Psoriasis)	696.1			
Skin Condition (Abnormal Moles)	238.2			
Sleep Apnea	780.57			
Stomach Ulcer	531.90			
Stroke	434.91			
Thyroid (Nodule)	241.0			
Thyroid High (Overactive) / Hyperthyroidism	242.90			
Thyroid Low (Underactive) / Hypothyroidism	244.9			
Dental History:	*Code*	*Current*	*Past*	*Comments*
Amalgams/Silver Fillings				
Bridge(S)				
Crown(S)				
Denture(S)				
Implant(S)				
Jaw Pain				
Periodontal Disease				
Other (list):				
Other (list):				

SURGICAL HISTORY: Please check off any procedure or surgeries. List any abnormal finding or complications.

☐**NONE**

Surgical Procedure	*Code*	*Yes*	*Year*	*Comments*
Abdominal Surgery				
Appendectomy (appendix removal)				
Back Surgery (lumbar)				
Biopsy (location)				
Breast Biopsy		☐Right ☐Left ☐Both		
Breast Surgery		☐Right ☐Left ☐Both		
Colonoscopy				
Coronary Bypass				
Coronary Stent				
EGD (Stomach Endoscopy)				
Cataract				
Gallbladder Removal		☐ Laparoscopic		
Heart Surgery (other than coronary bypass)				
Hip Surgery		☐Right ☐Left ☐Both		
Hysterectomy (total, including ovaries)		☐ Laparoscopic ☐Vaginal ☐Abdominal		
Hysterectomy (partial, ovaries left)		☐ Laparoscopic ☐Vaginal ☐Abdominal		
Abdominal Surgery				
Appendectomy (appendix removal)				
Back Surgery (lumbar)				
Biopsy (location)				
Breast Biopsy		☐Right ☐Left ☐Both		
Breast Surgery		☐Right ☐Left ☐Both		
Colonoscopy				
Coronary Bypass				
Knee Surgery		☐Right ☐Left ☐Both		
LEEP (Cervix Surgery)				
Neck Surgery				
Ovary Ligation (“Tubal”)				
Ovary Removal				
Prostate Surgery				

Sigmoidscopy				
Sinus Surgery				
Surgical Procedure	***Code***	***Yes***	***Year***	***Comments***
Tonsillectomy				
Tonsillectomy & Adenoids				
Vasectomy				
Other (list):				
Other (list):				

FEMALE MEDICAL HISTORY: *(For women only)*

OBSTETRICS HISTORY

Check box if yes, and provide number of pregnancies and/or occurrences of conditions

- ❑ Pregnancies_____ ❑ Caesarean _____ ❑ Vaginal deliveries_____
- ❑ Miscarriage _____ ❑ Abortion _____ ❑ Living Children_____
- ❑ Postpartum depression___ ❑ Toxemia _____ ❑ Gestational diabetes_____

GYNECOLOGICAL HISTORY

Age at first menses?_____ Frequency:_____ Length:_____

Painful: ☐ Yes ☐ No Clotting: ☐ Yes ☐ No

Date of last menstrual period:____/____/_____

Do you currently use contraception? ☐ Yes ☐ No If yes, what please indicate which form:

Non-hormonal

- ❑ Condom
- ❑ Diaphragm
- ❑ IUD
- ❑ Partner vasectomy
- ❑ Other (non-hormonal-please describe)_____

Hormonal

- ❑ Birth control pills
- ❑ Patch
- ❑ Nuva Ring
- ❑ Other (please describe)_____

Even if you are *not* currently using conception, but have used hormonal birth control in the past, please indicate which type and for how long._____

Do you experience breast tenderness, water retention, or irritability (PMS) symptoms in the second half of your cycle? ☐ Yes ☐ No

Please advise of any other symptoms that you feel are significant._____

Are you menopausal? ☐ Yes ☐ No If yes, age of menopause_____

Do you currently take hormone replacement? ☐ Yes ☐ No

If yes, what type and for how long?_____

☐ Estrogen ☐ Estradiol tablet ☐ Estradiol patch ☐ Estradiol pellet ☐ Estradiol vaginal cream
☐ Estradiol vaginal insert ☐ Estrace
☐ Premarin ☐ Progesterone capsule ☐ Progesterone cream ☐ Provera
☐ Testosterone cream ☐ Testosterone pellets ☐ Testosterone injection ☐ Testosterone vaginal
☐ Other _____ ☐ Other _____ ☐ Other _____

Vanguard Medical Center
"Life through Balance"

HORMONE CONSULTATION REGISTRATION

LIFESTYLE:

Tobacco: ☐ Never ☐ Ready to quit ☐ Not ready to quit
☐ Past Smoker Start Date: _____ Quit Date: _____ # Years Smoked: _____
☐ Cigars ☐ Cigarettes ☐ Chewable # PPD: _____
☐ Current Smoker
☐ Cigars ☐ Cigarettes ☐ Chewable
Years Smoked: _____ # PPD: _____ ☐ Intermittent ☐ # Cigarettes _____
☐ Smokeless Tobacco
Years Smoked: _____ # Can/PPD: _____ ☐ Intermittent ☐ # Cigarettes _____

Alcohol: ☐ Never ☐ Ready to quit ☐ Not ready to quit
Frequency: ☐ Rare ☐ Social ☐ Occasionally ☐ Daily ☐ Binge
Quantity: ☐ # Drinks/Day _____ ☐ # Drinks Per Week _____
Type of Alcohol: _____ # Previous Attempt to Quit? _____

Caffeine: ☐ None
☐ Caffeine/Tea/Soda (circle one or more) # Servings per Day: _____
☐ Coffee ☐ Tea ☐ Soda

Recreational Drugs: ☐ Never ☐ Past Quit Date: _____ ☐ Current User
Drug: _____ Have you ever used needles to inject drugs? ☐ Yes ☐ No

Exercise: Do you exercise regularly? ☐ Yes ☐ No What kind of exercise? _____
How long (minutes)? _____ How often? _____

Safety: Do you use a bike helmet? ☐ No bike ☐ Yes ☐ No
Do you use seatbelts consistently? ☐ Yes ☐ No
Does your home have a working smoke detector? ☐ Yes ☐ No
If you have guns in your home, are they locked up? ☐ Not applicable ☐ Yes ☐ No
Is violence at home a concern for you? ☐ Yes ☐ No

Sexual Activity:
Sexually involved currently: ☐ Yes ☐ No Sexual partner(s) is/are/have been: ☐ Male ☐ Female
Birth control method (select all that apply):
☐ None needed ☐Condom ☐Pill ☐Diaphragm ☐Vasectomy ☐Other _____

SOCIAL HISTORY:

Because stress has a direct effect on your overall health and wellbeing that often leads to illness, immune system dysfunction, and emotional disorders, it is important that your health care provider is aware of any stressful influences that may be impacting your health. Informing your doctor allows him/her to offer you supportive treatment options and optimize the outcome of your health care.

STRESS/PSYCHOSOCIAL HISTORY

Are you overall happy? ☐ Yes ☐ No
Do you feel you can easily handle the stress in your life? ☐ Yes ☐ No
If no, do you believe that stress is presently reducing the quality of your life? ☐ Yes ☐ No
If yes, do you believe that you know the source of your stress? ☐ Yes ☐ No
If yes, what do you believe it to be? _____
Have you ever contemplated suicide? ☐ Yes ☐ No
If yes, how often? _____ When was the last time? _____
Have you ever sought help through counseling? ☐ Yes ☐ No
If yes, what type? (e.g., pastor, psychologist, etc) _____
Did it help? ☐ Yes ☐ No

SLEEP & REST HISTORY

Average number of hours that you sleep at night? ☐ Less than 10 ☐ 8-10 ☐ 6-8 ☐ Less than 6
Do you:
☐ Have trouble falling asleep? ☐ Have trouble staying asleep? ☐ Snore?
☐ Feel rested upon wakening? ☐ Yes ☐ No
☐ Use sleeping aids? ☐ Have problems with insomnia?

Vanguard Medical Center
"Life through Balance"

HORMONE CONSULTATION REGISTRATION

FAMILY HEALTH HISTORY: Please indicate current and past history to the best of your knowledge.

☐ **NONE**

Check Family Members that Apply	**Father**	**Mother**	**Brother(s)**	**Sister(s)**	**Children**	**Maternal Grandmother**	**Maternal Grandfather**	**Paternal Grandmother**	**Paternal Grandfather**
Age (if still living)									
Age at death (if deceased)									
Heart Attack									
Stroke									
Uterine Cancer									
Colon Cancer									
Breast Cancer									
Ovarian Cancer									
Prostate Cancer									
Skin Cancer									
ADD/ADHD									
ALS or other Motor Neuron Diseases									
Alzheimer's									
Anemia									
Anxiety									
Arthritis									
Asthma									
Autism									
Autoimmune Diseases (such as Lupus)									
Bipolar Disease									
Bladder disease									
Blood clotting problems									
Celiac disease									
Dementia									
Depression									
Diabetes									
Eczema									
Emphysema									
Environmental Sensitivities									

Vanguard Medical Center
"Life through Balance"

HORMONE CONSULTATION REGISTRATION

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Epilepsy									
Flu									
Genetic Disorders									
Glaucoma									
Headache									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing spondylitis)									
Inflammatory Bowel Disease									
Insomnia									
Irritable Bowel Syndrome									
Kidney disease									
Multiple Sclerosis									
Nervous breakdown									
Obesity									
Osteoporosis									
Other									
Parkinson's									
Pneumonia/Bronchitis									
Psoriasis									
Psychiatric disorders									
Schizophrenia									
Sleep Apnea									
Smoking addiction									
Stroke									
Substance abuse (such as alcoholism)									
Ulcers									

HORMONE CONSULTATION REGISTRATION

Hormone Analysis for Women

Key: 1=Mild (occurs monthly, 2=Moderate (occurs weekly), 3=Severe (occurs daily) Leave blank if symptom does not occur

Estrogens Low		Estrogen High (Progesterone High)	
Hot flashes		Mood swings	
Night sweats		Breast tenderness	
Vaginal dryness		Water retention	
Scanty or no menses		Foggy thinking	
Incontinence		Irritability	
Depressed/tearful		Anxiety	
Disturbed sleep		Fibrocystic breasts	
Bone loss		Weight gain especially hips	
Foggy thinking / memory lapse		Heavy periods and/or clots	
Hair loss		Headaches	
Progesterone High		Uterine fibroids	
Increased acne		Fatigue	
Drowsiness		Cold body temperature	
Breast swelling			
Nausea			
Depression			
Foggy thinking			
Oily skin			
Testosterone/DHEA high		**Testosterone/DHEA low**	
Weight gain		Depression	
Insulin resistance		Fatigue	
Loss of scalp hair		Decreased sex drive	
Polycystic ovaries		Decreased muscle mass	
Irritability		Muscle aches/stiffness	
Acne		Bone loss	
Oily skin		Joint aches/pains	
Estrogens Low		**Estrogen High (Progesterone High)**	
Excess facial or body hair		Water retention	
Sore nipples		Reduced sexual performance	

Hormone Analysis for Men

Key: 1=Mild (occurs monthly, 2=Moderate (occurs weekly), 3=Severe (occurs daily) Leave blank if symptom does not occur

Date of last PSA: _____ Date of last prostate exam: _____

Thinning of hair on body		Abdominal weight gain	
Thinning of hair on beard		Poor concentration/memory loss	
Reduced libido		Lost of interest in surroundings	
Disturbed sleep		Night sweats	
Depression		Palpitations	
Prostate enlargement/cancer		Insomnia	
Muscle weakness		Thinning skin	
Fatigue		Slow wound healing	
Irritability		Anxiety	
Impotence		Baldness/Balding	

Endocrine Questionnaire

Key: 1=Mild (occurs monthly), 2=Moderate(occurs weekly), 3=Severe (occurs daily), Leave blank if symptom does not occur

Adrenal			
Decreased ability to handle stress		Headache if meals are skipped or delayed	
Feel most energetic after dinner		Irritable or shaky if meals delayed	
Difficulty waking up in the morning		Slow wound healing	
Headache/fatigue after exercising		"Nervous" stomach	
Chronic low back pain, worse with fatigue		Poor blood circulation in heart or arteries	
Become dizzy when stand up suddenly		Inflammation	
Difficulty with manipulative correction		Feeling wired or anxious	
Arthritic tendencies		Type A personality	
Crave salty foods		Wound up yet run down	
Perspire easily		Stressed and fatigued/sleep easily	
Increased efforts to do daily tasks		Stressed and sleep deprived	
Continuing fatigue not relieved by sleep		Exhaustion, insomnia, mild depression	
Lack of energy		Very sensitive to environmental pollutants	
Poor physical stamina, strength, & endurance		Autoimmune conditions	
Decreased mental focus or clarity		Migraines/headaches	
Mental Fatigue		Get sick easily	
Feeling depressed or low for no reason		Irritable or shaky if meals delayed	
Lack of motivation		Weight gain around waist	
Crave sweets or carbs		High Blood pressure	
Fatigue relieved by eating		Insulin resistance	
Loss of scalp hair		Impaired memory	
Low Thyroid			
Difficulty losing weight		Chronic constipation	
Mentally sluggish/reduced initiative		Excessive hair loss or course hair	
Easily fatigued/sleepy during the day		Morning headaches, wear off during day	
Sensitive to cold/poor circulation		Seasonal sadness	
High Thyroid			
Trouble gaining weight even with large appetite		Flush easily	
Nervous, emotional can't work under pressure		Fast pulse at rest	
Inward trembling		Intolerance to heat	

HORMONE CONSULTATION REGISTRATION

NUTRITIONAL HISTORY

Have you made any changes in your eating habits because of your health? ☐ Yes ☐ No

FOOD DIARY

Place a check mark next to the food/drink that applies to your current diet. (List continues on next page.)

Usual Breakfast	Usual Lunch	Usual Dinner
❑ None	❑ None	❑ None
❑ Bacon/Sausage	❑ Butter	❑ Beans (legumes)
❑ Bagel	❑ Coffee	❑ Brown rice
❑ Butter	❑ Eat in a cafeteria	❑ Butter
❑ Cereal	❑ Eat in restaurant	❑ Carrots
❑ Coffee	❑ Fish sandwich	❑ Coffee
❑ Donut	❑ Fried foods	❑ Fish
❑ Eggs	❑ Hamburger	❑ Green vegetables
❑ Fruit	❑ Hot dogs	❑ Juice
❑ Juice	❑ Juice	❑ Margarine
❑ Margarine	❑ Leftovers	❑ Milk
❑ Milk	❑ Lettuce	❑ Pasta
❑ Oat bran	❑ Margarine	❑ Potato
❑ Sugar	❑ Mayo	❑ Poultry
❑ Sweet roll	❑ Meat sandwich	❑ Red meat
❑ Sweetener	❑ Milk	❑ Rice
❑ Tea	❑ Pizza	❑ Salad
❑ Toast	❑ Potato chips	❑ Salad dressing
❑ Water	❑ Salad	❑ Soda
❑ Wheat bran	❑ Salad dressing	❑ Sugar
❑ Yogurt	❑ Soda	❑ Sweetener
❑ Oat meal	❑ Soup	❑ Tea
❑ Milk protein shake	❑ Sugar	❑ Vinegar
❑ Slim fast	❑ Sweetener	❑ Water
❑ Carnation shake	❑ Tea	❑ White rice
❑ Soy protein	❑ Tomato	❑ Yellow vegetables
❑ Whey protein	❑ Vegetables	❑ Other: (List below)
❑ Rice protein	❑ Water	
❑ Other: (List below)	❑ Yogurt	
	❑ Slim fast	
	❑ Carnation shake	
	❑ Protein shake	

How much of the following do you consume each week? Please give quantity (cups, # of slices or pieces, ect.)

FOODS	PORTIONS, CUPS, # OF PIECES
Candy	
Cheese	
Chocolate	
Cups of coffee containing caffeine	
Cups of decaffeinated coffee or tea	
Cups of hot chocolate	
Cups of tea containing caffeine	
Diet soda	
Ice cream	
Salty foods	
Slices of white bread (rolls/bagels, etc)	
Soda with caffeine	
Soda without caffeine	

Do you currently follow a special diet or nutritional program? ☐ Yes ☐ No

☐ Ovo-lacto ☐ Vegan ☐ Blood type diet ☐ Diabetic

☐ Dairy restricted ☐ Gluten restricted ☐ Vegetarian

☐ _____ ☐ Other (describe) _____

HORMONE CONSULTATION REGISTRATION

Please tell us if there is anything special about your diet that we should know.

Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, etc? ☐ Yes ☐ No
If yes, are these symptoms associated with any particular food or supplement? ☐ Yes ☐ No
If yes, please name the food or supplement and symptom(s): _____

Do you feel that you have delayed symptoms after eating certain foods, such as fatigue, muscle aches, sinus congestion, etc? (symptoms may not be evident for 48 HOURS or more) ☐ Yes ☐ No

Do you feel worse when you eat a lot of?

☐ High fat foods
☐ High protein foods
☐ High carbohydrate foods (breads, pasta, potatoes) ☐ Refined sugar (junk food)
☐ Fried foods
☐ 1 or 2 alcoholic drinks
☐ Other_____

Do you feel better when you eat a lot of?

☐ High fat foods
☐ High protein foods
☐ High carbohydrate foods (breads, pasta, potatoes) ☐ Refined sugar (junk food)
☐ Fried foods
☐ 1 or 2 alcoholic drinks
☐ Other_____

HORMONE CONSULTATION REGISTRATION

Key: 1=Mild (occurs monthly), 2=Moderate(occurs weekly), 3=Severe (occurs daily) Leave blank if symptom does not occur

Vitamin Need			
Muscles become easily fatigued		Can hear heart beat on pillow at night	
Feel exhausted or sore after moderate exercise		Whole body or limp jerk as falling asleep	
Vulnerable to insect bites		Night sweats	
Loss of muscle tone, heaviness in arms/legs		Restless leg syndrome	
Enlarged heart or congestive heart failure		Cracks at corner of mouth (Cheilosis)	
Pulse below 65 per minute		Fragile skin, easily chaffed, as in shaving	
Ringing in the ears (tinnitus)		Polyps or warts	
Numbness tingling, or itching in hands/feet		MSG sensitivity	
Depressed		Wake up without remembering dreams	
Fear or impending doom		Small bumps on back of arms	
Worrier, apprehensive anxious		Strong light at night irritates eyes	
Nervous or agitated		Nosebleeds and/or tend to bruise easily	
Feelings of insecurity		Bleeding gums when brushing teeth	
Heart races			
Digestive System			
Bad breath (halitosis)		Food allergies/sensitivities	
Sweat has a strong odor		Sinus congestion, "stuffy head"	
Excessive foul smelling lower bowel gas		Airborne allergies	
Undigested food in stools		Taken antibiotic for total accumulated time of (0=never, 1=<1 month, 2=<3 month, 3=>3 months)	
Sense of excess fullness after means		Fungus or yeast infections	
Bloating within 1 hour or eating		Heartburn or acid reflux	
Are you a vegan?		Feel better if you don't eat	
Loss of taste for meat		Stomach upset by taking vitamins	
Stools hard or difficult to pass		Bloating/gas/belching 1 to 2 hours after eating	
Anus Itches		History of parasites (0=no, 1=yes)	

HORMONE CONSULTATION REGISTRATION

PAIN ASSESSMENT QUESTIONNAIRE

Are you currently in pain? ☐ Yes ☐ No
Is the source of your pain due to an injury? ☐ Yes ☐ No
If yes, please describe your injury and the date in which it occurred:

_____
_____

If no, please describe how long you have experienced this pain and what you believe it is attributed to:

_____
_____

Please Use the Area(S) And Illustration Below to Describe The Severity Of Your Pain.
(0= no pain, 10= severe pain)

Example: **Neck** _____
1 2 3 4 5 6 (7) 8 9 10

Area 1. _____
1 2 3 4 5 6 7 8 9 10

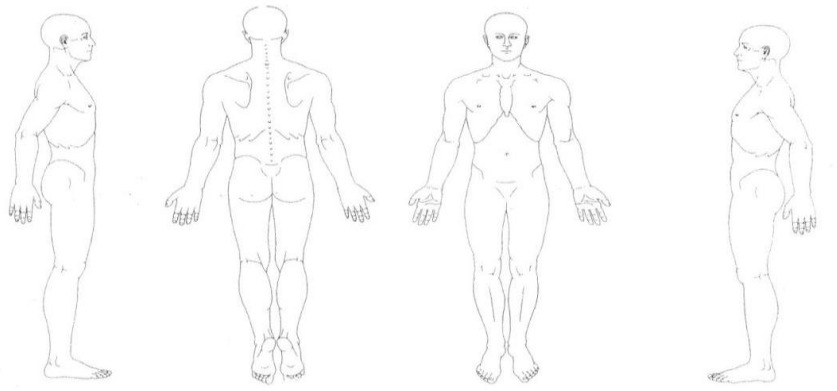
Area 2. _____
1 2 3 4 5 6 7 8 9 10

Area 3. _____
1 2 3 4 5 6 7 8 9 10

Area 4. _____
1 2 3 4 5 6 7 8 9 10

Use the Letters Provided to Mark Your Area(S) Of Pain On The Illustration.

A = Ache **B**= Burning **N**=Numbness **S**= Stiffness **T**=Tingling **Z**=Sharp/Shooting



HORMONE CONSULTATION REGISTRATION

OVERALL HEALTH RATINGS

Please Use the Following Scale to Describe the Severity: (0= NO symptom, 10= Severe symptom)

****** IMPORTANT: DO NOT LEAVE BLANK******

Example: _____0 1 2 3 4 (5) 6 7 8 9 10

Fatigue: **(0= NO symptom)** 0 1 2 3 4 5 6 7 8 9 10 **(10= Severe symptom)**

Sleep Quality: **(0= NO symptom)** 0 1 2 3 4 5 6 7 8 9 10 **(10= Severe symptom)**

Pain: **(0= NO symptom)** 0 1 2 3 4 5 6 7 8 9 10 **(10= Severe symptom)**

Stress: **(0= NO symptom)** 0 1 2 3 4 5 6 7 8 9 10 **(10= Severe symptom)**

GI: **(0= NO symptom)** 0 1 2 3 4 5 6 7 8 9 10 **(10= Severe symptom) Symptom: _____**
Location: _____

Sex Drive: **(0= NO symptom)** 0 1 2 3 4 5 6 7 8 9 10 **(10= Severe symptom)**

By My Signature, I Attest That I Have Read and Answered This Questionnaire Truthfully. (MANDATORY)

Date: _____-_____-_____

Patient Signature or Representative: _____ **Print Name:** _____

Thank you for taking the time to complete this health history medical questionnaire. The information derived from all of these forms will provide invaluable data in identifying the underlying problems of your health concerns rather than simply treating the symptoms alone.
Welcome to Vanguard Medical Center and we look forward to helping you achieve lifelong health and well-being.

Sincerely,

Frandzie Daphnis MSN, FNP-BC