Westchester
WELLNESS & MEDICINE

# Male Patient Questionnaire & Medical History

Name:_____ Date:_____

Date of Birth:_____ Age:_____ Occupation:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell:_____ Work:_____

Email:_____

How did you hear about us?_____

Primary Care Physician:_____

Pharmacy Name:_____

Pharmacy Address:_____

Marital Status:_____ Weight:_____ Height:_____

What is the reason for your visit?_____

_____

_____

List all your symptoms:

_____

_____

_____

_____

## History:

Are you sexually active? Yes / No

Do you have a history of Prostate Cancer or Prostatitis?_____

If Yes, What Therapy?_____

Have you ever experimented with Anabolic Steroids?_____

If Yes, What, When and for how long? _____

_____

Have you ever used Testerone? _____ If Yes, When?_____

Medical History: _____

_____

_____

Surgical History: _____

_____

_____

Allergies:_____

Medications: _____

_____

_____

Supplements/Vitamins:_____

_____

_____

Habits: Smoking:_____Alcohol intake:_____Recreational Drugs:_____

Do you exercise?_____How Often?_____

What type of exercise? _____

_____

Describe **1 full typical day's meals, snacks, and drinks,** and time of each (please be specific and very complete):

**Breakfast:**_____

_____

_____

**Snacks (All)**:_____

_____

_____

**Lunch:**_____

_____

_____

**Dinner:**_____

_____

_____

**Alcohol:**_____

_____

_____

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## Assessment Plan

# HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov.

**We have adopted the following policies:**

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

# HIPAA Information and Consent Form

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I,_____(Date)_____
do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

_____
Signature

_____
Date

# Insurance Disclaimer

Preventative medicine and bio-identical hormone replacement is a unique practice and is considered a form of alternative medicine. Even though your provider is a board-certified MD, insurance does not recognize it as necessary medicine BUT is considered like plastic surgery (aesthetic medicine) and therefore, is not covered by health insurance in most cases.

Westchester Wellness Medicine is not associated with any insurance companies, which means insurance companies are not obligated to pay for our services (consultations, insertions or pellets).

We require payment at the time of service and, if you choose, we will provide a form to send to your insurance company and a receipt showing that you paid out of pocket. WE WILL NOT, however, communicate in any way

with insurance companies. The form and receipt are your responsibility and serve as evidence of your treatment. We will not call, write, pre-certify, or make any contact with your insurance company. Any follow up letters from your insurance to us will be discarded. If we receive a check from your insurance company, we will not cash it, but instead return it to the sender. Likewise, we will not mail it to you. We will not respond to any letters or calls from your insurance company.

For patients who have access to Health Savings Account, you may pay for your treatment with that credit or debit card. This is the best idea for those patients who have an HSA as an option in their medical coverage.

**Name:**_____

**Signature:**_____

**Date:**_____