The Hormone Restoration Center
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New Patient Registration

PATIENT INFORMATION

First_____ Middle_____ Last_____

Preferred Name_____ Date of Birth_____ Social Security #_____

Legal Gender (Please circle) Male Female

CONTACT INFORMATION

Email Address (We use this for appointment reminders.)_____

Phone Number_____ Alternate Number_____

Address: Street_____ City_____ State_____ Zip_____

OCCUPATION INFORMATION

Employer_____ Occupation_____

EMERGENCY CONTACT

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

DEMOGRAPHICS

Language (Please circle) English Spanish French Other

Race (Please circle) American Indian/Alaskan Native Asian Black/African American
Hispanic/Latino Native Hawaiian/Pacific Islander White/Caucasian Do not wish to disclose.

Marital Status (Please circle) Single Married Divorced Separated Widow Partner

PREFERRED PHARMACY

Pharmacy Name_____ Location_____ Phone_____

HOW DID YOU HEAR ABOUT US?

Friend/Family/Word of mouth (Who?) _____

Online Search (Google / Bing / Other) Search term used? _____

Advertisement (Print/Online/Radio/social media) _____

MEDICATION ALLERGIES **REACTIONS**

1._____/_____ Mild Moderate Severe

2._____/_____ Mild Moderate Severe

3._____/_____ Mild Moderate Severe

4._____/_____ Mild Moderate Severe

PAST MEDICAL HISTORY **PAST SURGERIES**

1._____ 1. _____

2._____ 2. _____

3._____ 3. _____

4._____ 4. _____

5._____ 5. _____

MEDICATIONS **VITAMINS**

1._____ Dose: _____ 1. _____ Dose: _____

2._____ Dose: _____ 2. _____ Dose: _____

3._____ Dose: _____ 3. _____ Dose: _____

4._____ Dose: _____ 4. _____ Dose: _____

5._____ Dose: _____ 5. _____ Dose: _____

6._____ Dose: _____ 6. _____ Dose: _____

7._____ Dose: _____ 7. _____ Dose: _____

SMOKER (Please circle) Never Former Present Packs a day? _____ Age started_____

ALCOHOL (Please circle) Never Rare Occasional Weekly

How many drinks? _____ What kind? _____

ESTIMATED HEIGHT:_____ **ESTIMATED WEIGHT**_____

FAMILY HISTORY

Mother Alive / Deceased Age_____ Medical Problems_____

Father Alive / Deceased Age_____ Medical Problems_____

Brother/Sister Alive / Deceased Age_____ Medical Problems_____

Brother/Sister Alive / Deceased Age_____ Medical Problems_____

Brother/Sister Alive / Deceased Age_____ Medical Problems_____

Brother/Sister Alive / Deceased Age_____ Medical Problems_____

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 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 the administrative areas such as the front office, examination room, etc. Those records will not be available to people other than the 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 several vendors in the conduct of business. These venders 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 physician.
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.
8. We may change, add, delete, or modify any of these provisions to better serve the needs of 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 hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information and Consent Form and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

PRINT_____ **SIGN**_____ **DATE**_____

Communication Consent

We do our best to maintain the privacy of patients' personal, financial and health data. However, in order to practice medicine, we believe it is necessary to communicate with patients using methods such as cell phones, text messages, and/or email. Unfortunately, because these methods of communication are not always encrypted to government standards, with double password protection on both ends of communication, HIPAA (the government) considers these forms of communications to be nonsecure. Because of this, we are not allowed to use this because of potential breaches of your personal health information. This may sound silly but it's true. So, we require that you sign below to confirm that you are comfortable with these methods of communication.

I hereby authorize Dr. Richard Chern and his staff to communicate with me by non-secure, unencrypted methods of communication to include cellular phone, text, and/or email. I understand that these methods may not be secure and may lead to a breach of my personal, financial, and health information.

SIGN_____**PRINT**_____**DATE**_____

Permission to Speak About Treatment

In the event we cannot contact you by the means you've provided above, we would like to know if we have permission to speak to your spouse, significant other, family member, or friend about your treatment. By giving the information below you are giving us permission to speak with your spouse, significant other, family member, or friend about your treatment.

Name_____ Relationship to patient_____

Name_____ Relationship to patient_____

Name_____ Relationship to patient_____

PRINT_____**SIGN**_____**DATE**_____

Office Policies and Procedures for our patients

Thank you for choosing The Hormone Restoration Center. We realize that you have a choice of medical providers and are pleased that you have chosen to seek care with us. The staff at THRC strives to exceed expectations in care and service to make your experience with us as comfortable and stress free as possible. Our goal is to provide quality medical care in a timely manner.

OFFICE HOURS Our office is available Monday – Thursday between 9:00am and 4:30pm and may be reached at **(850) 837-1271**. Our fax number is **(855) 845-9276**. If you need an appointment, prescription refill(s) and/or test results, please call during regular business hours.

APPOINTMENT THRC is committed to providing quality care for our patients. To ensure timely continued care, we encourage patients to schedule appointments in advance of follow up due dates. When calling for an appointment, please provide your name, telephone number, chief complaint/reason for visit, as well as any updated contact information. To ensure quality care, THRC does not treat patients that we have not seen (i.e., we will not call-in prescriptions or offer medical advice for patients prior to their initial visit). A follow-up may be required to be scheduled after testing has been completed, so that results may be reviewed together and an appropriate and effective plan for your healthcare can be determined.

CANCELLATION OF AN APPOINTMENT In order to be respectful of the medical needs of our patients, please be courteous and call our office promptly if you are unable to attend an appointment. This time will be reallocated to someone who needs treatment. This is how we can best serve the needs of our patients. If it is necessary to cancel your appointment, we do require that you call 24 hours in advance. Appointments are in high demand and your early cancellation will give another person the opportunity to have access to timely medical care.

NO SHOW POLICY A "no show" is someone who misses an appointment without cancelling it within 24 hours. No shows inconvenience those individuals who need access to medical care in a timely manner. A failure to present at the time of a scheduled appointment will be recorded in your medical chart as a "no show", as well as a fee of $40.00.

INSURANCE THRC does not accept or file any insurance of any kind. We are more than happy to provide you with a charge sheet of your payment received and services rendered. You can submit that charge sheet to your insurance company for reimbursement. Patients are responsible for payment at the time of service.

PAYMENTS THRC accepts cash, Mastercard, Discover, Visa and American Express. Unfortunately, we do not accept checks.

PATIENT PORTAL We encourage you to sign up for the patient portal. You will have access to your medical records and lab results and can print them should you need to provide a copy to another party. An invitation will be sent to you, via email, at your office visit. After you have registered for your account, you can visit the portal at any time by following the URL: HTTPS://20418.PORTAL.ATHENAHEALTH.COM/

PRESCRIPTION REFILLS &PHARMACY INFORMATION Please inform THRC which pharmacy you use and update us if this should change. Please allow 1-2 business days for refill requests. We encourage our patients to review their medications prior to their office visits and to request those refills at that time, if needed. Please note that we DO NOT fill narcotic medication or order antibiotics over the phone. Our practice does not routinely order narcotic pain medicine; therefore, you may be required to obtain those medications through pain management.

MEDICAL RECORDS Per HIPAA guidelines, copies of medical records must be requested in writing. To ensure your privacy, a form for the release of medical information must be completed prior to the receipt of these materials. Please review the following Florida laws and statutes regarding charges for medical records:

Florida Statutes 395.3025 Records requested by someone other than the patient:

- Exclusive charge for copies may include sales tax and actual postage.
- Non-paper records not to exceed $2.00 per page.
- Paper records not to exceed $1.00 per page.
- A fee of up to $1.00 may be charged for each year of records requested.

Florida Statutes 395.301 Itemized Patient Bill

- The facility may not charge the patient for making such verification records available; however, the facility may charge its usual fee for providing copies of records as specified in s. 395.3025.

Rule 64B8-10.003, Florida Administrative Code Records requested by the patient or governmental entities:

- For the first 25 pages, the cost shall be $1.00 per page.
- For each page more than 25 pages, the cost shall be $0.25 per page.
- Actual cost of reproducing non-written records such as x-rays. The phrase "actual costs" means the cost of the material and supplies used to duplicate the record, as well as the labor costs and overhead costs associated with such duplication.
- "Recognizing that patient access to medical records is important and necessary to assure continuity of patient care, the Board of Medicine urges physicians to provide their patients a copy of their medical records, upon request, without cost, especially when the patient is economically disadvantaged."

By signing below, I acknowledge that I have received, reviewed, understand, and will comply with the policies and procedures explained in The Hormone Restoration Center OFFICE POLICIES & PROCEDURES FOR PATIENTS form.

SIGN_____**PRINT**_____**DATE**_____

HRT Male Health History & Symptoms

Name: _____ **Date:** _____

Symptoms (Please mark the appropriate box for each symptom you may be experiencing)	**X**
Physical Exhaustion (fatigue, lack of energy, stamina or motivation)	
Sleep Problems (difficulty falling asleep or sleeping through the night)	
Irritability (mood swings, feeling aggressive, angers easily)	
Anxiety (feeling overwhelmed, feeling panicky, or feeling nervous)	
Decline in drive or interest (loss of "zest for life", feeling down or sad)	
Joint & muscular symptoms (joint pain, muscle weakness, poor recovery after exercise)	
Difficulties with memory (concentration, finding the right word, or retaining information)	
Sexual Desire or Performance (reduced or diminished)	
Erectile Changes (weaker erections, loss of morning erections)	
Ejaculations (Infrequent or Absent)	
Sweating (night sweats or increased episodes of sweating)	
Hair loss, thinning or change in texture of hair	
Feeling cold all the time, having cold hands or feet	
Headaches or migraines (increase in frequency or intensity)	
Weight (difficulty losing weight despite diet/exercise)	
Bladder problems (difficulty in urination, increased need to urinate, incontinence)	

Any drug allergies? YES NO If YES, please list: _____
Any changes in medications since last visit? YES NO If YES, please list: _____

Patient Questions:

YES NO Currently trying to conceive?

YES NO Desire to conceive in the future?

YES NO Is the patient on a 5-Alpha Reductase Inhibitor (Finasteride, Dutasteride, etc.)?

YES NO Is the patient on a PDE-5 Inhibitor (Cialis, Viagra, etc.)?

YES NO Is the patient on any other testosterone boosting medication (Clomid, HCG, etc.?)

YES NO Is the patient currently on statins (drugs that can lower your cholesterol)?

YES NO Is the patient currently on oral nitrates (drugs to treat angina (chest pain) and heart failure)?

YES NO Is the patient a smoker?

YES NO Is the patient currently utilizing Bioidentical Hormone Replacement Therapy or Hormone Replacement Therapy?

If YES, select the types of hormones you are currently utilizing:

☐ **Testosterone Type (Please Circle):** Pellet Cream/Gel Injection **Dose:** _____

☐ **Thyroid Name/Dose:** _____

Medical History (Select all that apply)

Fertility

YES **NO** Patient wants to maintain fertility

Cardiovascular Conditions

YES **NO** Heart Attack or Stroke (within last 6 months)
YES **NO** DVT or Blood Clot (within last 6 months)
YES **NO** Hypertension
YES **NO** Hyperlipidemia
YES **NO** Obstructive Sleep Apnea
YES **NO** Patient Takes Anticoagulant Medication
YES **NO** Atrial Fibrillation

Cancer

YES **NO** Breast Cancer or History of Breast Cancer
YES **NO** Active Prostate Cancer or History of Prostate Cancer
YES **NO** Thyroid Cancer or History of Thyroid Cancer
YES **NO** Meningioma
YES **NO** Polycythemia Vera (PV)
YES **NO** Any Other Cancer Excluding Basal Cell Carcinoma

Endocrine and Metabolic

YES **NO** Diabetes Type 2 or Insulin Resistance
YES **NO** Hyperthyroid (Overactive Thyroid)
YES **NO** Hypothyroid (Underactive Thyroid)

Autoimmune Conditions

YES **NO** Diabetes Type 1
YES **NO** Hashimoto's Thyroiditis
YES **NO** Graves' Disease
YES **NO** Rheumatoid Arthritis
YES **NO** Multiple Sclerosis
YES **NO** Systemic Lupus (Erthemoatosus)
YES **NO** Psoriasis
YES **NO** Positive ANA
YES **NO** IBS (Irritable Bowel Syndrome)
YES **NO** Crohn's Disease
YES **NO** Ulcerative Colitis

Organ Specific Conditions

YES **NO** Liver Disease or History of Liver Disease
YES **NO** Kidney Disease or History of Kidney Disease
YES **NO** LAM (Lymphangioleimyomatosis)
YES **NO** Osteoporosis or Osteopenia
YES **NO** HIV
YES **NO** Hepatitis
YES **NO** Hemochromoatosis