Phoenix Men's Health Center, PLLC
New Patient Intake Forms

Today's Date: _____

Patient Intake Form- Please print in Black ink.

Patient Name and Contact Information

Legal Name: Last_____First_____

Middle_____

(Date of birth) _____/____/____ Age_____ Sex : M F

Other names on record_____

Home Street Address: _____City_____ State_____

Zip_____ Is this the same as your shipping address? Yes No

Single Married Divorced Partnered Widowed Student –FT or PT (Please circle choice)

Spouse/Partner Name_____ Daytime # _____

Is it ok to leave messages with your spouse/partner regarding your treatment or scheduling with PhxMHC? Yes No

Email address_____

Would you like to prescribe to online newsletter Y N

(Confidential medical information cannot be sent over email. PhxMHC will respect patient confidentiality and will only send confidential medical information over the internet if a waiver has been signed)

Home number ( )_____ Cell ( ) _____ Other ( )_____

May we leave confidential voicemails at any of the above numbers? Yes No

If we can leave a confidential message please specify by circling: Home Cell Other

Please list in order of importance your main health complaints. The severity of your condition may be determined by the physician and referred to your Primary care Physician, Urgent Care, or ER.

Top 3 Goals for your health:
1
2
3

Treatment options previously used for some of the above conditions?

_____

Phoenix Men's Health Center, PLLC
New Patient Intake Forms

Allergies (Please list all known allergies including environmental, medications, foods, supplements, cleaning products, beauty products)

Allergen	Amount	When it was discovered?	Medications for treatment?	Self care for treatment of allergens?
1.				
2.				

Lifestyle:

Any alcohol addiction Yes No Past Treatment Yes No Past

Recreational Drugs Yes No Past Type _____

Any Drug addictions Yes No Past Treatment Yes No Past

Answer below, how you feel about each.

Your energy level?	**Low**	1	2	3	4	5	6	7	8	9	10 **High**
Your sex drive, Libido?	**Low**	1	2	3	4	5	6	7	8	9	10 **High**
Erection strength?	**Poor**	1	2	3	4	5	6	7	8	9	10 **Great**
Your sleep?	**Poor**	1	2	3	4	5	6	7	8	9	10 **Great**
Your diet?	**Poor**	1	2	3	4	5	6	7	8	9	10 **Great**
Your exercise?	**Never**	1	2	3	4	5	6	7	8	9	10 **Frequent**
Your health?	**Poor**	1	2	3	4	5	6	7	8	9	10 **Great**
Your happiness?	**Unhappy**	1	2	3	4	5	6	7	8	9	10 **Very Happy**

Any lifestyle questions/events/habits that you think may be affecting your health?

_____

What are you lifestyle goals or changes that you would like change, and are seeking answers for?

_____

Your Current Weight_____ Weight One Year ago_____ Height_____

Phoenix Men's Health Center, PLLC
New Patient Intake Forms

Date:_____ **Patients Name**_____

Release of liability (Must be signed before any health care services will be provided)

Any information given in person/email/phone/text provided to patients/potential patients/customers or inquires **is not medical advice** for the treatment or cure of any disease, unless specified by a licensed PhxMHC medical provider during a scheduled medical visit.

It is recommended that your Primary Care Physician be notified of all of your medical conditions appropriately after you have been seen at the PhxMHC. The patient agrees to take the responsibility of informing their practitioners both primary care/allopathic and alternative/traditional/integrative of all medical treatments and updates in their health care.

PhxMHC/PhxNMDC provides health care specializing in allopathic/alternative/traditional/integrative/naturopathic treatments for **Medical Weight Loss (Diabetes, Metabolic Syndrome, Obesity, Overweight), Thyroid Management, HRT (Hormone Replacement Therapy for Men and Women, Peri-Menopause, Menopause, Andropause, Erectile Dysfunction), And Erectile Dysfunction.** For any medical condition that cannot be managed by PhxMHC physicians will be referred out to the patients Primary Care Physician, ER, Urgent Care or Specialist. The patient acknowledges that they will follow through with the referral for further medical care.

I have read the above release of liability and understand that my seeking of additional health care should/can be cleared by my primary care physician. I am seeking assistance from the PhxMHC for additional/alternative/traditional/integrative medical care. If my medical needs are not meet either by any recommendation or if I feel I need additional care, I will take responsibility for contacting my Primary Care Physician for additional medical services.

I will make my Primary Care Physician aware of my past/current and future intentions for medical treatments, traditional/alternative/acupuncture/botanical medicine/homeopathy/colon hydrotherapy/sauna/detoxification/yoga/massage/myoskeletal/naturopathic, and I will request the clearance from my primary care physician. **I will inform Phoenix Men's Health center if I would like them to become my new Primary Care Physician.**

I release liability from any PhxMHC medical provider/employee/staff/volunteer or instructor for any treatments/care/advice if it has not first been discussed or approved by/with my Primary Care Physician. I understand that it is my responsibility to keep my primary care physician aware/updated on my seeking of additional health care with/and/or/for traditional/alternative/acupuncture/botanical medicine/homeopathy/colon hydrotherapy/sauna/detoxification/yoga/massage/myoskeletal/naturopathic/integrative medicine.

Sign Here: I _____ (print) have read the above statement and agree to all information contained within._____**Signature**._____**Date**

Consent to treat: I understand that I may be receiving acupuncture, homeopathy, botanical medicine, colon hydrotherapy, myoskeletal work, naturopathic care, Nutrient/chelation/cancer IV, and allopathic care (Integrative Medicine) for the treatment of my health condition. I understand that acupuncture treatments in the state of Arizona are not a primary health care modality. If I choose to have one or any of the above treatments, I must maintain contact with my primary care physician I understand that seeking Walk-In, Integrative Medical, Naturopathic, Colon Hydrotherapy treatment does not replace seeing my primary care physician.

***Initial_____**I would like the possibility to receive acupuncture, homeopathy, botanical medicine, colon hydrotherapy, myoskeletal work, Nutrient/cancer/chelation IV, and allopathic care. I will maintain my primary care physician

-I understand that the potential benefits of acupuncture, homeopathy, botanical medicine, colon hydrotherapy, myoskeletal work, and naturopathic care include drugless relief of my symptoms and an improved state of health. I understand that the potential risks of acupuncture include local discomfort and bruising, with a potential for infection at the site of the needle insertion.

-In addition, I understand that I may be prescribed Chinese or American herbs to take to help relieve my condition. I understand that Chinese and American herbal formulas are not regulated in the state of Arizona and that under rare circumstances people experience certain side effects from the herbs.

-With my understanding of the above, I voluntarily consent to receive acupuncture, homeopathy, botanical medicine , colon hydrotherapy, myoskeletal work, IV Immune support, IV chelation, IV nutrient care, and allopathic care/treatment. I am fully aware of any potential complications and am able/healthy enough/of sound mind and body to seek further medical advice/assistance from my other health care practitioners. _____**Initial***

Signature of patient or person authorized to provide consent: _____Date_____

Phoenix Men's Health Center, PLLC
New Patient Intake Forms

Financially Responsibility

Who is financial responsible for your medical treatment? _____

All payment for services provided are due at the end of each medical visit. It is understood and accepted by the patient/ client that medical services can be discontinued for late/missing/absent payments for services/supplements/medications. This includes and is not limited to patient medication refills, prescription writing, time with physician, phone calls, e-mails, text messaging and communication. Patient will be made aware of their financial standing before services may be discontinued. The patient is seeking traditional/alternative/acupuncture/botanical medicine/homeopathy/colon hydrotherapy/sauna/detoxification/yoga/massage/myoskeletal/IV nutrient/cancer/chelation naturopathic health care. Payments may be collected in cash, credit, debit, or check. **Trading of professional services is not available for any medical treatments.**

Cash based Pricing:
-**$299-$350** for initial visits. Primary Care/Integrative Testosterone Therapy $299 & Womens BHRT $350.
-**$189** Primary care /Integrative, 30min Follow Up visits, prescription writing, prescription refills, phone calls/text messaging initiated by patient/client, plus any medication/supplementation/acupuncture/homeopathy or physical adjustments.
-We reserve the right to bill according to our desecration, case complexity, time, and case circumstances.
-Phone calls/text messaging/emails, prescription writing/prescription refills, patient services, **patient out of network insurance paperwork** will be charged in 15min increments, based on $299/hr.
-**A minimum charge of $189 for prescription refills, prescribing, or alterations made to medications over the phone or email. All Prescription Rx medication require a 3 month office visit or phone consult, $189.**
-Shipping charges and sales tax will be applied to all drop ship supplements and medications.
-All supplements and medications sold in office will have a city and state sales tax applied.
-Services on the phone, text, email or other forms of communication out side of office visits will be billed in 15min increments at $299 per hour, presented on patient billing as Doctor/Patient Medical Consultations
-Credit Card, Debit Card transactions will have a 3% "swipe fee", to cover transactions fees associated with card.
-**Concierge Rates are available**. Unlimited doctor visit, contacts, Rx's, and 25% discount on all services and medications, including Testosterone and ED Medications.

I understand that the medical services I am seeking will be charged on an 15, 30, & 60min bases for physician & office services, this includes office time, phone consultations, case research, and emails. All other services (physical adjustments), medications, supplements, IV's will be billed in addition to the physicians & office time and included in my invoices/bills/statements. I understand that the times to be billed are at the discretion of the health clinic.

Please initial ____ Patient signature_____ Patient or Guardians Signature_____ Date ___/___/___

PhxMHC does not currently accept or take any medical insurance, (Cigna Excluded) all statements, master billing sheets, can be submitted to your insurance company, medical savings account, for reimbursement. Credit Debit Card information.

Name on Card_____ Card #_____ Type_____
Expiration Date_____ Security code_____

Your information will be kept confidential with your medical records following HIPPA rules and regulations.

Phoenix Men's Health Center, PLLC
New Patient Intake Forms

Policy and Record Release Acknowledgement Form

Record Release: By completion of this form, I hereby acknowledge and authorize the release of my records to myself at the above contact information at any requested time. This request may be denied where applicable laws compel PhxMHC to do so.
If you would like your medical records mailed to a different address, please provide the address below:

_____

_____

Request for Medical Records. PhxMHC follows HIPAA regulations for processing medical records release at all times. A signature form is required to process any and all request for the release of medical records. Records being forwarded to a medical facility for concurrent medical care are not assessed a fee. Personal request for copies of medical records are assessed a fee of 50 cents per page, or 25 dollars for a complete chart and are sent by regular mail to the last known home address on records, or requested provider/insurance agency.

Patient signature _____**Date**_____
Guardian signature_____**Relationship**_____**Date**_____

Privacy Terms: An Electronic Medical Record of healthcare services will be created and maintained by PhxMHC. Applicable state and federal laws protect the confidentiality of your medical records and information as well as grant you the right to see or obtain a copy of records we will have on file electronically or hardcopy. Your medical information will not be disclosed to others unless we are directed to do so in writing or applicable laws authorize or compel us to do so. PhxMHC is required to provide you, at your request, with a copy of its Notice of Privacy Practices and to obtain a written acknowledgment that you have reviewed it. The notice outlines the types of uses and disclosures that may occur involving your protected health information, explaining your rights and you may exercise those rights. If you have any questions concerning the management of your healthcare information at our clinic, or wish to inquire about your rights, please contact PhxMHC at 602-908-5422.
I hereby acknowledge that I have been offered a copy of the PhxMHC Notice of Privacy Practices. Patient's signature_____**Date**_____
Guardian's signature_____ **Relationship**_____
_____**I refuses to acknowledge these terms.**
Printed Patient/Guardian Name_____**Date**_____

Phoenix Men's Health Center, PLLC
New Patient Intake Forms

Role of PhxMHC in your health care: Physicians are licensed naturopathic medical doctors in the state of Arizona. Patients are encouraged to inform the physician if they would like the doctors to act as their PCP or other practitioner in their health care. If patient does not specify with the practitioner, PhxMHC will not be functioning as your primary care physician.
Any health concerns that cannot be accommodated for at PhxMHC will be referred to ER, Urgent Care, or the patients Primary Care Physician.

We are a cash based fee for service medical center. We reserve the right to discontinue medical services at any time and our patients have the right to discontinue medical services at any time.

Communication with office: Messages left for the doctor will be returned in the order they are received or by medical necessity. If you do not receive a phone call within 24hrs please call back and leave another message. Any phone call to the doctor regarding new conditions or existing conditions may result in a consultation fee based on time discussing condition.
All communication must be by voice mail, phone call, email (phxmhc@gmail.com), or online scheduling software (GenBook). **Text messages are not an acceptable form of communication for medical information** and will not receive any responses from our office.

During normal business hours please call: Phoenix Men's Health Center (602) 908-5422

- In the event of an emergency dial 911

Cancellation Policy

- All scheduled appointments require 24hr prior notice of cancellation
- **Cancelations within 24hrs assess a late cancelation fee of 50% of scheduled office visit**.
- Patients who miss two consecutive appointments without calling to reschedule, or any attempts to reschedule may/will be/are releasing themselves from medical care.

Supplemental Sales

All sales are final for supplemental products, botanical medications, multi-vitamins, minerals, and homeopathic remedies.

I have read and understand the policies and procedures information above. I agree to the terms stated above.

Patient Name_____**Date**_____
Guardian Signature_____**Relationship**_____

Phoenix Men's Health Center, PLLC
New Patient Intake Forms

Notification of Privacy Policy

To our patients. This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy
Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances
The following circumstances may require us to use or disclose your health information:
1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information
1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Phoenix Men's Health Center-2601 N. 3rd St., Suite 304, Phx, AZ 85004.
Note: *We must respond to this request within 30 days.*
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Phoenix Men's Health Center-2601 N. 3rd St, Suite 304, Phx, AZ 85004. You must provide us with a reason that supports your request for amendment.
Note: *We must respond within 60 days. The Privacy Officer or the patient's physician will usually do this. If the physician believes the information is complete and accurate, the physician can refuse to make any changes.*
5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact the front desk receptionist.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Office Manager of Phoenix Natural Medicine and Detox Center or Dr. Le Provost with Phoenix Men's Health Center. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact the Office Manager at Phoenix Men's Health Center

Phoenix Men's Health Center, PLLC
New Patient Intake Forms

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, acknowledge that I have received a copy of the Phoenix Men's Health Center Notice of Privacy Policies.

Patient or legally authorized individual signature _____ Date _____

Printed Name if signed on behalf of the patient _____Relationship (parent, legal guardian, persons Representative, etc.) _____

I authorize and agree that Phoenix Men's Health Center, PLLC (PhxMHC) may disclose my protected health information to the following persons, each of who is directly involved in my care:

1._____ 2._____

3._____ 4._____

I acknowledge and agree that Phoenix Men's Health Center (PhxMHC) may disclose my protected health information to the persons set forth in this form unless and until I object to such disclosures, which must be provided in writing to PhxMHC at the Phoenix Natural Medicine and Detox Center.

Patient or legally authorized individual signature
_____

Date
_____

Printed Name if signed on behalf of the patient
_____

Relationship (parent, legal guardian, personal Representative, etc.) _____

Below is for office/business use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because (please specify):

_____

Phoenix Men's Health Center, PLLC
New Patient Intake Forms

Pricing Policy

Your Personal Care and Health is 100% of our focus.

We are a "cash" pay practice . We accept HSA, Credit/Debit, Checks & Cash.
No insurance plans.

Insurance may be used here for blood work only, and you may submit claims to your insurance for possible deductibles and reimbursements.

Office fees are associated with all office visits, prescription refills, phone consultations, disability claims, out side paper work/forms and office work.
50% of Office Visit for Cancelation and No Show within 24hrs

New Patient office visits: $299
*Required lab work and medications are not included.

Follow Up office visits: $189
*Required lab work, medications, are not included. Costs vary on patient needs.
*Medication adjustments, Lab Review, treatment plan assessment/adjustments.
*Any patient on prescription meds will require at least 3 Follow up visits a year.
*Include medication refills and adjustments. Most common visit.

Patients receiving any prescription medications must be seen in the office every quarter (4 times a year) for **Follow Up** office visits and have relevant lab work at least every 6 months.

Phoenix Men's Health Center, PLLC
New Patient Intake Forms

Lab Work Policy/Agreement:

IF you have INSURANCE:

- We use Vibrant America Labs, they are an out of network lab

What out-of-network means:

- Your insurance company has the choice of helping to pay for your labs or not. This does not mean you will get the bill for the labs.
- We send your insurance card in with your blood work. Your insurance company may send you an **Explanation of Benefits (EOB)** that may look like a bill. This is telling you what the insurance will cover or not. This is not a bill, even if it says you owe something. **Vibrant will not charge you what your insurance does not cover.**
- **IF** your insurance chooses to **NOT COVER** the lab work, then what you owe will be a number we will discuss with you when drawing your blood. This number will be based off what is drawn, so may be different every time you get your blood drawn.
- **IF** your insurance chooses to **COVER** some of your blood work, then you may be billed a smaller amount than we quoted you.
- **You will NOT be billed for what your insurance denies to cover.**

IF you do NOT have insurance:

- We use Access labs for our patients without insurance. We have chosen this lab as they seem to have the least expensive prices for patients.
- This will be **cash pay**
- **New Patient Lab Work recommended can come to approx. $345**
- This is just a recommendation. It depends on what you are coming in for. So labs may be more or less depending on what is discussed in your appointment.
- Follow up lab work will depend entirely on what is discussed in your appointments. It is different for every patient.
- List of cash prices for the **Most COMMON labs run:**

CBC: $10	CMP: $10
Lipid Panel (Cholesterol): $25	TSH and FT3(Thyroid Hormones): $42
Testosterone Total and Free: $45	Prostate Specific Antigen: $35
Fasting Insulin: $25	HbA1c: $20
DHEA-s: $20	FSH and LH: $40
Vitamin D: $30	Cortisol: $30
Estradiol: $25	Blood Draw Fee: $15