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Kristin Tarbet, MD, Mike Symond, MD & Gay Sleight, PA-C

PATIENT INFORMATION

Patient Name: ______________________________________

Address: ____

City: ________________________State: _____ Zip: ________

Home Phone: (_____) _________Cell: (_____) ____________

Age: ________________Date of Birth: __________________

Email: ____

Gender: Male Female Marital Status: M S W D

Social Security Number: ______________________________

Employer: ____

Employer Address: __________________________________

Employer Phone: (_____) ______________________________

Nearest Relative: ____________________________________

Address: ____

Phone #: (_____) ____________ Relation: _______________

Responsible Party or Spouse

Name: ____

Address: ____

City: ________________________State: _____ Zip: ________

Home Phone: (_____) _________________________________

Date of Birth: ______________ SS#: ___________________

Employer: ____

Employer Address: ___________________________________

Employer Phone: (_____) _______________________________

Credit Policy & Financial Agreement

Each patient, not the insurance company, is responsible for payment for all charges to his/her account at the time services are rendered unless special arrangements are made in advance.
I authorize insurance benefits to be paid directly to Kristin Tarbet, MD/Mike Symond, MD/Gay Sleight, PA-C. I also authorize the physician to release any information acquired in the course of my evaluation or treatment to the insurance company.
Payments on accounts billed are expected within 30 days.
Delinquent accounts will be charged interest at 1½% per month. I agree to pay collection costs and/or reasonable attorney's fee if any delinquent balance is placed with an agency or attorney for collection or suit.
I/We agree to pay all attorney's fees, court costs, filling fee (including charges of commissions), that may be assessed by any collection agency retained to pursue this matter. I/We further understand that this may be as much as 50% of the principal owing. I/We further agree to pay interest at the rate of 1 ½% per month (18% per year).

ATTENTION: IMPORTANT INSURANCE INFORMATION

Since it is vital that our patients understand our relationship with insurance companies this statement is necessarily straightforward to prevent any possible misunderstandings, disagreements or disappointments.
If you believe that your medical needs are covered by insurance, please be aware that the health insurance contract you have is between you and your insurance company, not Amara and your company. We work with your insurance company on all claims, however the insurance company does have a final say as to what is and is not covered. In the event that your insurance company refuses payment for services rendered, you will be responsible for payment in full.

LAB INSURANCE MAY NOT COVER ALL FEES

If you have insurance, all labs costs are submitted to your insurance company by the Laboratory, not by Amara. We can't guarantee the payment to the lab company by your insurance, as the contract you have is between you and your insurance company.

Patient Initials: _____

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, private insurance and other health plans to Kristin Tarbet, MD/Mike Symond, MD/Gay Sleight, PA-C. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information and records necessary to secure the payment. To the extent necessary to determine liability for payment, and obtain reimbursement, I authorize disclosure of portions of my medical records. A photocopy of the assignment is considered as valid as original.

______________________________ ________________
Signature of Patient Date

______________________________ ________________
Signature of Responsible Party Date

______________________________ ________________
Witness Date

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Name: ______________________________ DOB: ______________ Date: ____________

Present/Previous Occupation: ______________________________ Marital Status: S M D W

Past Medical History

- ☐ High blood pressure
- ☐ Hear attack
- ☐ Heart failure
- ☐ Heart valve problems
- ☐ Liver disease/Hepatitis
- ☐ Anemia
- ☐ Depression
- ☐ Mental illness
- ☐ Stroke/Mini stroke
- ☐ Brain Tumor
- ☐ Cancer: ______________
- ☐ Diabetes: Type I or Type 2
- ☐ Gout
- ☐ Epilepsy/Seizures
- ☐ Abnormal Clotting
- ☐ Permanent Make up: ________
- ☐ Over-active thyroid
- ☐ Under-active thyroid
- ☐ Asthma
- ☐ Lung problems
- ☐ Ulcers
- ☐ Kidney Disease
- ☐ Arthritis
- ☐ Other: __________

Women: # of pregnancies: _____ # of live births: _____

Have you had any surgeries?

Type of Surgery	Hospital	Year

Please list your medications, include herbs/vitamins.

Medication	Dose	Medication	Dose

Family Medical History

Have any of your blood relatives had any of the diseases listed above?

Relative:	Living?	Deceased?	List Diseases:	Cause of Death
Father				
Mother				
Sister/s				
Brother/s				
Grandparents				

Personal & Social History

List members in household

Name:	Birthday

Do you have smoke detectors in home? Y / N
Do you use a seatbelt? Y / N
Do you exercise? Y / N How often? ________
Do you use Alcohol? Y / N How often? ________
Did you ever use alcohol? Y / N How long? ________
Do you smoke cigarettes/chew tobacco? Y / N How often?___ X ____
Do you ever use illegal drugs? Y / N
If yes, what kind? ______________
Did you ever use illegal drugs? Y / N
If yes, what kind? ______________

Immunizations:
Did you complete your childhood series? Y / N
Last Tetanus booster? ________________
Last Pneumonia shot? ________________
Last TB skin test? ________________
Last Hep B series? ________________
Last Flu shot? ________________
Other: ________________

Have you ever had any of following procedures? What year?
Chest X-ray:__________ ECG:__________ Holter:__________ Stress test:__________
Echocardiogram:__________ Angiogram:__________ PFT's:__________ Overnight oximetry:__________
Sleep study:__________ PSA:__________ Pap smear:__________ Mammogram:__________

Do you have any allergies to medications? Y/N If yes, please list what kind of reaction?

____

Are you seeing any specialists? Y/N If yes, please list:

____

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MEN'S BHRT SYMPTOMS QUESTIONAIRE

Name: ____ Date: ___________________

Family History: Do you have a family history of any of the following?

Prostate Cancer	□Yes	□No	Relationship: ________________________
Blood Clots	□Yes	□No	Relationship: ________________________
Heart Disease	□Yes	□No	Relationship: ________________________
Osteoporosis	□Yes	□No	Relationship: ________________________
Diabetes	□Yes	□No	Relationship: ________________________

Please rate the following symptoms: 0= rarely a problem, 1= mild, 2= moderate, 3= severe

___ Difficulty concentrating
___ Loss of hair
___ Headache
___ Feeling of depression
___ Anxiety
___ Fatigue
___ Increased body & facial hair
___ Weight gain
___ Difficulty sleeping
___ Unable to reach orgasm
___ Moodiness
___ Body Pain
___ Foggy thinking
___ Sugar/food cravings
___ Memory loss
___ Low libido

___ Dry hair or skin
___ Inability to ejaculate
___ Loss of muscle mass
___ Low ejaculation volume
___ Can't maintain erection
___ Difficulty getting erection
___ Low erection quality
___ Loss of motivation
___ Irritability
___ Increase breast size
___ Increased waist size
___ Inability to lose weight
___ Acne/oily skin
___ Constipation
___ Joint Pains
___ Backaches

Any other symptoms not listed:
____
____
____
____

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CONSENT FOR HORMONE SUPPLEMENTATION THERAPY

I, _______________________________ specifically authorize Kristin Tarbet, MD, Mike Symond, MD, and/or Gay Sleight, PA-C to perform an evaluation and develop a suggested plan for my individual optimal health. I warrant that all information that I have submitted for my evaluation is true to the best of my knowledge.

I request and consent to the administration of hormones and oral supplements and authorize that these will be prescribed by Gay Sleight, PA-C. I acknowledge that there are no guarantees or promises made with respect to how well I will benefit from the hormone supplementation therapy prescribed to me.

I understand that initial blood and/or saliva tests will be performed to establish my baseline hormone levels. I agree to comply with reasonable requests for follow-up testing to assure proper monitoring of my hormone levels. I agree to report to the doctor any adverse reaction or problem that might be related to my hormone therapy.

I understand that with hormone supplementation there are possible risks and complications if I do not comply with the recommended dosages. I understand that I will be in charge of administering the hormones and supplements prescribed to me. I will conform and comply with the recommended dosages and methods of administration. I understand that the role of is for the management of my preventative anti-aging health plan and hormone replacement only. I agree that I will be under the care of another health care provider for all other medical conditions. I agree that Gay Sleight PA-C will not take the place of my personal medical provider in this regard.

I have been informed that insurance companies and Medicare do not pay for hormone supplementation therapy. I therefore agree to pay for all services including laboratory and pharmacy charges myself, with the understanding that I will no be reimbursed by my insurance company for laboratory and pharmacy charges.

I have read and understand all of the above consent. I have also been provided with additional information about hormone supplementation therapy so that I fully understand what I am signing. I hereby request and consent to treatment using hormone supplementation therapy.

Patient Signature: ____ Date: _____________

Physician Signature: ______________________________________ Date: _____________

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CONSENT FOR TESTOSTERONE REPLACEMENT THERAPY

I, ______________________________ the undersigned, request from Kristin Tarbet, MD, Mike Symond, MD or Gay Sleight, PA-C to be prescribed Testosterone as a treatment of my medical condition.

- I understand that this prescription for Testosterone is indicated either for the treatment of Androgen Deficiency of the Aging Male (ADAM), sometimes called Andropause or Hypogonadism, or Testosterone Deficiency, based upon my medical history, physical findings and laboratory tests.

- I understand that Kristin Tarbet, MD, Mike Symond, MD and Gay Sleight, PA-C cannot guarantee any positive results or that there will be no side effects or harm. The goal and potential benefit of this therapy is to prevent, reduce or control the symptomatic dysfunction that occurs as a result of testosterone deficiency or the aging process and the low testosterone production that occurs in aging males.

- I understand that the conventional medical community and many Medical Doctors believe that Testosterone supplementation is contra-indicated in a patient with past history of prostate cancer and/or prostatic hypertrophy (BPH). I have been fully informed, and I am totally satisfied with my understanding that this proposed treatment may be viewed by the conventional medical community as new, controversial or detrimental, and unnecessary by the Food and Drug Administration, given the present state of knowledge regarding the human aging process.

- While a study published in the New England Journal of Medicine, January 2004, reviewed 72 medical studies and found no evidence that testosterone therapy causes prostate cancer, I understand that questions have been raised about Testosterone as a cause of prostate cancer, since it is an anabolic hormone and can increase the growth rate of cancer cells.

- I understand that side effects may occur with the use of Testosterone. Possible side effects may include oily skin, acne, moodiness, irritability, slight bruising at the injection site, increased hematocrit, exacerbation of sleep apnea, alteration of lipid profile, increased blood pressure, and insulin resistance. I agree to cease using the testosterone and contact my provider and if necessary, seek immediate medical attention, in the event I knowingly develop any adverse side effects.

- I understand that the use of exogenous testosterone may result in a mild to moderate testicular atrophy and a lowered sperm count, and that my ability to father children may be lessened.

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- I understand the importance of maintaining a healthy lifestyle with the use of Testosterone, and agree to continue with a recommended program of healthful nutrition, regular exercise, stress management and nutritional supplementation with the use of Testosterone. I further agree to continue any other hormone replacement therapies recommended by my physician.

- I understand that careful monitoring is crucial with Testosterone replacement therapy and agree to comply with the following monitoring recommendations while receiving Testosterone replacement therapy:

  1. Testosterone; Free and Total levels, PSA, CBC, estradoil, fasting glucose, fasting insulin and hemoglobin A1C are measured initially, then 8-10 weeks after initial replacement and are repeated every 6 months thereafter.

  2. PSA is measured every 6 months in men over the age of 40.

  3. Other hormone levels may be monitored, as well as other blood tests appropriate for treatment.

  4. Assessment for physical side effects 4-8 weeks after initial replacement and every 2-6 months thereafter.

  5. Annually: Physical examination, baseline blood testing, baseline prostate exams.

- I understand the potential risks and contraindications associated with the use of Testosterone Replacement Therapy, and that the alternative is to leave the hormone levels as they are and do nothing.

- I certify that I have read the above consent and fully understand it. I believe I have adequate knowledge upon which to base information consent. I fully understand what I am signing and hereby request and consent to treatment using supplemental exogenous Testosterone.

Patient Signature: ____ Date: _____________

Physician Signature: ______________________________________ Date: _____________

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INSTRUCTIONS FOR BLOOD TESTING

Fasting Blood draws

INSULIN: Take medication as prescribed.

CHOLESTEROL & TRIGLYCERIDES: Take medication 10 – 12 hours prior to test.

NON-Fasting Blood draws

THYROID: Take 5 hours prior to blood being drawn.

TESTOSTERONE:
- Pellets: Recheck labs 30 days after initial insertion
- Oral: Do not take day of test or troche
- Injections: If injected weekly, test must be drawn 4 days after injection topical; women: do not apply day of test. Men, get labs 5-6 hours after application.

ESTROGEN:
- Patch: Wear as prescribed
- Oral: Take as prescribed
- Topical: Don't apply the morning of testing
- Injections: Tests should be done 4th day after the last injection

PROGESTERONE: Do not take night before or morning of test
- Troche: Take 4 – 6 hours before test
- S.R. (Sustained release) Oral: Must take within 10 hours before testing
- Topical: Don not apply morning of test

DHEA: Take as prescribed, unless applied in cream form then do not use the day of no longer than 12 hours prior to testing

GROWTH HORMONE: Don't take dose the night before testing

****It is always OK to drink water before blood testing*

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Menopausal women:

1. Most hormone labs need follow up blood work in 3 months. If balanced then annual (blood test) follow up thereafter

Premenopausal women: *(Gay will tell you which test you need follicular or luteal)*

1. Follicular phase – labs drawn on day 2-3 of menses
2. Luteal phase – labs drawn on day 17-20 of menses
3. If not menstruating because of IUD or ablation etc. then a random lab draw will be drawn (this may be followed up in two weeks)

Men:

1. Initial Testosterone recheck in 6 weeks
2. Two PSA (Prostate Specific Antigen) per year

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PRIVACY PRACTICES ACKNOWLEDGEMENT

Acknowledgement Form

I am aware of, have received or been offered a copy of Amara's Notice of Privacy Practices and I have been given the opportunity to review it.

Date: ________________________

Birth date: ___________________

Patient Printed Name: ____

Patient Signature: ____

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