AMARA

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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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WOMEN'S BHRT SYMPTOMS QUESTIONAIRE

Name: ____ Date: ________________________

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

Uterine Cancer	☐Yes	☐ No	Relationship: _________________________
Ovarian Cancer	☐Yes	☐ No	Relationship: _________________________
Blood Clots	☐Yes	☐ No	Relationship: _________________________
Breast Cancer	☐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 pubic hair
___ Night sweats
___ Low body temperature
___ Headache
___ Hair loss
___ Heart palpitations
___ Hot flashes
___ Fibrocystic breasts
___ Leaky bladder
___ Feeling of depression
___ Painful intercourse
___ Anxiety
___ Fatigue
___ Weight gain
___ Constipation
___ Increase in facial hair
___ Vaginal dryness
___ Difficulty sleeping
___ Yeast infections
___ Unable to reach orgasm
___ Moodiness
___ Body pain
___ Uterine fibroids
___ Urinary tract infections
___ Tender breasts
___ Foggy thinking
___ Sugar/food cravings
___ Memory loss
___ Bloating
___ Low libido
___ Dry hair or skin
___ PMS

Are you still menstruating? Yes No ______________________________

If yes, are your periods regular? Yes No ______________________________

Have you had a hysterectomy? Yes No ______________________________

Have you gone through menopause? Yes No ______________________________

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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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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