NEW PATIENT QUESTIONNAIRE

Name:_____ Today's Date:_____
(Last) (First) (Middle Initial)

Date of Birth:_____ Age:_____ Occupation:_____

Home Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work:_____

Email Address:_____

How did you hear about us? Patient Name:_____ Other:_____

In Case of Emergency Contact:_____ Relationship:_____

Cell Phone:_____ Home Phone:_____ Work:_____

MEDICAL HISTORY

Height:_____ Weight:_____ Last Menstrual Period:_____ Hysterectomy? ( ) No ( ) Partial ( ) Full

Do you smoke? ( ) Yes ( ) No ( ) Quit How much?_____ How often?_____ Age started?_____

Do you drink alcohol? ( ) Yes ( ) No ( ) Quit How much?_____ How often?_____ Age started?_____

Any known drug allergies: ( ) Yes ( ) No If yes please explain:_____

Current Medications and dosage:_____

_____

_____

Nutritional/Vitamin Supplements: _____

Current Hormone Replacement Therapy:_____ Past HRT: _____

Surgeries, list all and Year:_____

Other Pertinent Information: _____

Do you have a personal history of? **Check all that apply.**

Preventative Medical Care:
( ) Medical/GYN Exam in the last year
( ) Mammogram in the last 12 months
( ) Bone Density in the last 12 months
( ) Pelvic ultrasound in the last 12 months

High Risk Past Medical/Surgical History:
( ) Breast Cancer
( ) Uterine Cancer
( ) Ovarian Cancer
( ) Hysterectomy with removal of ovaries
( ) Hysterectomy only
( ) Oophorectomy Removal of Ovaries
( ) Prostate Cancer

Birth Control Method:
( ) Menopause
( ) Hysterectomy
( ) Tubal Ligation
( ) Birth Control Pills
( ) Vasectomy
( ) Other:_____

Medical Illnesses:
( ) High blood pressure
( ) Heart bypass
( ) High cholesterol
( ) Hypertension
( ) Heart Disease
( ) Stroke and/or heart attack
( ) Blood clot and/or a pulmonary emboli
( ) Arrhythmia
( ) Any form of Hepatitis or HIV
( ) Lupus or other auto immune disease
( ) Fibromyalgia
( ) Trouble passing urine or take Flomax or Avodart
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis)
( ) Diabetes
( ) Thyroid disease
( ) Arthritis
( ) Depression/anxiety
( ) Psychiatric Disorder
( ) Cancer Type:_____ Year: _____

_____ _____ _____
PRINT NAME **SIGNATURE** **DATE**

EvexiPEL®

MRS Checklist - BEFORE HRT

Which of the following symptoms apply at this time?
Place an "X" for EACH symptom. For symptoms that do not apply, please mark NONE.

	None	Mild	Moderate	Severe	Extremely Severe
1. **Hot flashes, sweating** (episodes of sweating)	☐	☐	☐	☐	☐
2. **Heart discomfort** (unusual awareness of heart beat, heart skipping, heart racing, tightness)	☐	☐	☐	☐	☐
3. **Sleep problems** (difficulty in falling asleep, difficulty in sleeping through the night, waking up early)	☐	☐	☐	☐	☐
4. **Depressive mood** (feeling down, sad, on the verge of tears, lack of drive, mood swings)	☐	☐	☐	☐	☐
5. **Irritability** (feeling nervous, inner tension, feeling aggressive)	☐	☐	☐	☐	☐
6. **Anxiety** (inner restlessness, feeling panicky)	☐	☐	☐	☐	☐
7. **Physical and mental exhaustion** (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)	☐	☐	☐	☐	☐
8. **Sexual problems** (change in sexual desire, in sexual activity and satisfaction)	☐	☐	☐	☐	☐
9. **Bladder problems** (difficulty in urinating, increased need to urinate, bladder incontinence)	☐	☐	☐	☐	☐
10. **Dryness of vagina** (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)	☐	☐	☐	☐	☐
11. **Joint and muscular discomfort** (pain in the joints, rheumatoid complaints)	☐	☐	☐	☐	☐

Please share any additional comments about your symptoms you would like to address.

Pellet Membership Pricing

Why? Because you need to give the pellet procedure a year to get your dosing and supplements right. Hormone optimization may not be felt fully after first treatment.

Annual Membership $275

Initial Consult

Initial Labs

Follow-up Labs

Follow-up Appointment

10% off supplements

Free B12 shot quarterly

**Benefits to having your lab work completed at Pelle: We have a lab that will have your results to us within 24-48 hours. The lab sends results directly to us, and we can schedule an appointment to get you back in for pellet insertion quickly, and you feeling better faster as a result. Our fee can also be turned in to your insurance company and may count toward your deductible.

Your Savings

Lab draws can be expensive and time intensive.

Consult: $50

Initial Labs: range from co-pay/upwards of $1400 depending on insurance.

Follow-up Labs: range from co-pay/upwards of $1400 depending on insurance.

Follow-up Appointment: $50

Boost if needed: $25

Supplements: $1074.00 annually (save 107.40)

EVEXIAS Medical Centers, PLLC

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Information. Your Rights. Our Responsibilities.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide mental health care

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

I acknowledge receipt and understanding of my rights.

PRINT NAME _____ SIGNATURE _____ DATE _____

Post-Insertion Instructions for Women

- Your insertion site has been covered with two layers of bandages.
    - Remove the outer pressure bandage any time after 3 to 4 hours. It **must** be removed as soon as it gets wet. You may replace it with a bandage to catch any anesthetic that may ooze out.
    - The inner layer is either waterproof foam tape or steri-strips. They should be removed in **3 days**. If the tape or steri-strip comes off you may replace it with a band-aid.
- We recommend putting an ice pack on the insertion area a couple of times for about 20 minutes each time over the next 4 to 5 hours.
- Do not take tub baths or get into a hot tub or swimming pool for **3 days**. You may shower but do not scrub the site until the incision is well healed (about 7 days).
- No major exercises for the incision area for the next **4 days**, this includes running, riding a horse, etc.
- The sodium bicarbonate in the anesthetic may cause the site to swell for 1-3 days. This is normal.
- The insertion site may be uncomfortable for up to 2 to 3 weeks. If there is itching or redness you may take Benadryl for relief, 50 mg. orally every 6 hours. Caution this can cause drowsiness!
- You may experience bruising, swelling, and/or redness of the insertion site which may last from a few days up to 2 to 3 weeks.
- You may notice some pinkish or bloody discoloration of the outer bandage. This is normal.
- If you experience bleeding from the incision, apply firm pressure for 5 minutes.
- Please call if you have any bleeding (not oozing) or pus coming out of the insertion site that is not relieved by pressure.

<u>Reminders:</u>

- **Remember to go for your post lab blood work 5 weeks after your initial insertion. This is VERY important.**
- Most women will need re-insertions of their pellets **4-5 months** after their initial insertion.
- Please call to make an appointment for a re-insertion as soon as symptoms that were relieved from the pellets start to return. The charge for the second visit will be only for the insertion and not a consultation.

New patients: Please make a follow up lab review appointment in 6 weeks:

I acknowledge that I have received a copy and understand the instructions on this form.

_____	_____	_____
PRINT – PATIENT NAME	**SIGNATURE – PATIENT NAME**	**DATE**

Rev 5-7-18

Patient Consent for Release of Protected Health Information (PHI)

I, _____, give my consent to Evexias Medical Centers, PLLC to release my protected health information (PHI) to include, but not limited to: physical exam results, lab results or other diagnostic studies, medication information/changes, appointments, billing information, etc. to the following individuals:

Name (Print Clearly)	**Relationship to Patient**
Name (Print Clearly)	**Relationship to Patient**
Name (Print Clearly)	**Relationship to Patient**

Consent (check ALL that apply):

I consent Evexias Medical Centers, PLLC to leave detailed messages regarding my healthcare, appointments, services, diagnostic test results or financial services at the following [**check ALL that apply**]:

☐ **Call** ☐ **Text** Phone:_____

☐ **Email** address:_____

This consent will expire only with written notification to contact@evexiasmedical.com

Patient Name (*Print Clearly*):_____

Patient Signature:_____ **Date:**_____

If a minor (under 18 years of age)

Parent or Guardian Name (*Print Clearly*):_____

Parent or Guardian Signature:_____ **Date:**_____

Statement of Patient Financial Responsibility

Patient Name: _____ **DOB:** _____

Evexias Medical Centers, PLLC (EMC) appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. We expect these payments at time of service. I agree to pay EMC the full and entire amount of treatment given to me or to the above named patient at each visit.

We only accept insurance as a form of payment for lab work. We can file with your insurance company or you can choose to pay our cost. If you choose to have your lab work filed with your insurance company instead of paying our cost, you are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. I understand and take full responsibility for any amounts not covered by my insurance carrier(s).

We provide paperwork for Pellet HRT that you can use to submit to your insurance company for reimbursement. I understand that EMC is unable to assist with any additional paperwork or requests made by patients or insurance providers.

Prescriptive medication requires a payment prior to it being ordered and is shipped to the clinic. Prescriptive medication is to be picked up within five business days of notification of its arrival to the clinic. I understand that if my medication expires between the pick up date requirement and the day I pick it up, I must pay in full for a new order of my prescriptive medication. I also understand that refunds or credits are not permitted on any prescriptive medication for any reason.

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call at least 24-hours prior to cancel your appointment. I understand if I *no show* or *cancel* an appointment two times in a row without notifying EMC within 24 hours, I will have to pay a $50 non-refundable fee before scheduling my next appointment.

I have read the above policy regarding my financial responsibility to Evexias Medical Centers, PLLC for providing any and all services to me, or the above named patient. I acknowledge that I am financially responsible for myself, or the above named patient.

Patient Name [PRINT]	**Patient Signature**	**Date**
Guarantor Name [PRINT]	**Guarantor Signature**	**Date**

(If guarantor is not the patient)

Rev 082818

TESTOSTERONE AND/OR ESTRADIOL PELLET INSERTION CONSENT FORM (FEMALE)

Patient Name:_____**DOB:**_____

Bio-identical hormone pellets are concentrated hormones, biologically identical to the hormones you make in your own body prior to menopause. Estrogen and testosterone were made in your ovaries and adrenal gland prior to menopause. Bio---identical hormones have the same effects on your body as your own estrogen and testosterone did when you were younger, without the monthly fluctuations (ups and downs) of menstrual cycles.

Bio-identical hormone pellets are made from yam and are FDA monitored but not approved for female hormonal replacement. The pellet method of hormone replacement has been used in Europe and Canada for many years and by select OB/GYNs in the United States. You will have similar risks as you had prior to menopause, from the effects of estrogen and androgens, given as pellets.

Patients who are pre---menopausal are advised to continue reliable birth control while participating in pellet hormone replacement therapy. Testosterone cannot be given to pregnant women.

My birth control method is: (please circle)

Abstinence Birth Control Pill Hysterectomy IUD Menopause Tubal Ligation Vasectomy Other

CONSENT FOR TREATMENT: I consent to the insertion of testosterone and/or estradiol pellets in my hip. I have been informed that I may experience any of the complications to this procedure as described below. These side effects are similar to those related to traditional testosterone and/or estrogen replacement. **Surgical risks are the same as for any minor medical procedure.**

Side effects may include:

Bleeding, bruising, swelling, infection and pain; extrusion of pellets; scarring at insertion site; keloid scar; hyper sexuality (overactive libido); lack of effect (from lack of absorption); breast tenderness and swelling especially in the first three weeks (estrogen pellets only); increase in hair growth on the face, similar to pre---menopausal patterns; water retention (estrogen only); increased growth of estrogen dependent tumors (endometrial cancer, breast cancer); safety of any of these hormones during pregnancy cannot be guaranteed. Notify your provider if you are pregnant, suspect that you are pregnant or are planning to become pregnant during this therapy, continuous exposure to testosterone during pregnancy may cause genital ambiguity; change in voice (which is reversible); clitoral enlargement (which is reversible). The estradiol dosage that I may receive can aggravate fibroids or polyps, if they exist, and can cause bleeding. Testosterone therapy may increase one's hemoglobin and hematocrit, or thicken one's blood. This problem can be diagnosed with a blood test. Thus, a complete blood count (Hemoglobin and Hematocrit) should be done at least annually. This condition can be reversed simply by donating blood periodically.

BENEFITS OF TESTOSTERONE PELLETS INCLUDE: Increased libido, energy, and sense of well-being. Increased muscle mass and strength and stamina. Decreased frequency and severity of migraine headaches. Decrease in mood swings, anxiety and irritability. Decreased weight. Decrease in risk or severity of diabetes. Decreased risk of heart disease. Decreased risk of Alzheimer's and dementia.

I agree to immediately report to my practitioner's office any adverse reaction or problems that might be related to my therapy. Potential complications have been explained to me and I agree that I have received information regarding those risks, potential complications and benefits, and the nature of bio---identical and other treatments and have had all my questions answered. Furthermore, I have not been promised or guaranteed any specific benefits from the administration of bio---identical therapy. I accept these risks and benefits and I consent to the insertion of hormone pellets under my skin. This consent is ongoing for this and all future insertions.

I understand that payment is due in full at the time of service. I also understand that it is my responsibility to submit a claim to my insurance company for possible reimbursement. I have been advised that most insurance companies do not consider pellet therapy to be a covered benefit and my insurance company may not reimburse me, depending on my coverage. I acknowledge that my provider has no contracts with any insurance company and is not contractually obligated to pre---certify treatment with my insurance company or answer letters of appeal.

_____ _____ _____

PRINTED NAME SIGNATURE DATE

pelle
— spa

Vitamin B12 Injection Consent Form

What are the possible benefits?

- Improved energy and stamina
- Improved sleep quality and duration
- Higher Metabolism
- Balanced immune system
- Mental clarity

How often can I do the injections?

- Vitamin B12 shots are the most effective when taken at regular intervals. We recommend once weekly for 4 weeks, followed by once a month. A regular injection schedule can be individualized.
- The cost is $25 per treatment and takes only a few minutes.

Facts about Vitamin B12

- Aging means we absorb less Vitamin B12 from food. It is estimated 85% of us come up short of the necessary B12 from our diet.
- Absorption of B12 in food requires a substance from our stomach called intrinsic factor, the production of which decreases with age. The American College of Physicians assumes that no one has the intrinsic factor past age 70.
- People with chronic fatigue or anemia require regular injections of vitamin B12 because the oral form is unreliable.

Side effects and warnings

- Some redness and swelling at the injection site may occur and should begin to clear up within 48 hours.
- Vitamin B12 is safe for most people. However, pregnant or lactating women should speak to their doctor prior to starting a B12 regimen.
- Sensitivity to cobalt and/or vitamin B12 is a contraindication.
- Clients with chronic liver and/or kidney dysfunction, Leber's disease (hereditary eye disease) or abnormal red blood cells (megoblastic anemia) should not take frequent B12 injections.

By signing below, I acknowledge that I have read the foregoing informed consent and agree to the treatment with its associated risks. I hereby give consent to perform this and all subsequent B12 injections.

Print Name: _____

Client Signature: _____ Date: _____