RESTORE
WELLNESS

Female Patient Questionnaire & History

Name: _____ Today's Date: _____

(Last) (First) (Middle)

Date of Birth: _____ Age: _____ Weight: _____ Occupation: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work: _____

E-mail Address: _____ May we contact you via E-Mail? ( ) Yes ( ) No

Emergency Contact: _____ Relationship: _____

Home Phone: _____Cell Phone: _____ Work: _____

Primary Care Physician's Name: _____ Phone Number: _____

Address: _____

Address City State Zip Code

Marital Status (check one) ◯ Married ◯ Divorced ◉ Widow ◯ Living with Partner ◯ Single

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

Spouse's Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Social History:

☐ I smoke (cigarettes or cigars) _____ per week/week.

☐ I drink alcoholic beverages _____ drinks, _____ times per week.

☐ I use caffeine, _____ cups per day.

☐ I am sexually active.

☐ I have completed my family.

Medical History

Any known drug/environmental (i.e. tape/adhesive) allergies: _____

Have you ever had any issues with anesthesia? ☐ Yes ☐ No

If yes please explain: _____

Medications Currently Taking: _____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Nutritional/Vitamin Supplements: _____

Surgeries, list all and when: _____

Last menstrual cycle (estimate year if unknown): _____

Other Pertinent Information: _____

Presentative Medical Care:

Date of last pap smear: _____

Date of last mammogram: _____

Date of last Bone Density: _____

Do you have a history of:

☐ Breast Cancer
☐ Uterine Cancer
☐ Ovarian Cancer
☐ None of the above

Have you had:

☐ Hysterectomy with removal of ovaries
☐ Hysterectomy (removal of uterus only)
☐ Oophorectomy (removal of ovaries only)

Birth Control Method:

☐ Menopause
☐ Hysterectomy
☐ Tubal Ligation
☐ Birth Control Pills
☐ Vasectomy
☐ Other: _____

Please mark any **Medical Illnesses:**

☐ High Blood pressure
☐ Heart bypass
☐ Hight 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
☐ Chromic liver disease (hepatitis, fatty liver, cirrhosis)
☐ Diabetes
☐ Thyroid disease
☐ Arthritis
☐ Depression/anxiety
☐ Psychiatric Disorder
☐ Cancer (type): _____

Year: _____

Health Assessment for Women

Name: _____ Date: _____

E-mail: _____

Symptom (please check mark)	Never	Mild	Moderate	Severe
Depressive mood	_____	_____	_____	_____
Fatigue	_____	_____	_____	_____
Memory Loss	_____	_____	_____	_____
Mental confusion	_____	_____	_____	_____
Sleep problems	_____	_____	_____	_____
Mood changes/Irritability	_____	_____	_____	_____
Tension	_____	_____	_____	_____
Migraine/severe headaches	_____	_____	_____	_____
Difficult to climax sexually	_____	_____	_____	_____
Bloating	_____	_____	_____	_____
Weight gain	_____	_____	_____	_____
Breast tenderness	_____	_____	_____	_____
Vaginal dryness	_____	_____	_____	_____
Hot flashes	_____	_____	_____	_____
Night sweats	_____	_____	_____	_____
Dry and wrinkled skin	_____	_____	_____	_____
Hair is falling out	_____	_____	_____	_____
Cold all the time	_____	_____	_____	_____
Swelling all over the body	_____	_____	_____	_____
Joint pain	_____	_____	_____	_____

Family History

	Yes	No
Heart Disease	_____	_____
Diabetes	_____	_____
Osteoporosis	_____	_____
Alzheimer's Disease	_____	_____
Breast Cancer	_____	_____

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 14th, 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 regulations on who may see or be notified of your Protect 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 is 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 administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents and 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 yo other communications information you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors 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 doctor.
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 the 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 you PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

_____	_____	_____
Print Name	Signature	Date

Medicare Waiver

This agreement is between the provider of Restore Wellness RGV, whose principal place of business is 725 E. Esperanza Ave Ste. B, McAllen, Texas 78501, and patient, _____, Date of Birth, _____, who resides at_____, and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to section 4507 of the Balanced Budget Act of 1997. The provider has informed the patient that they have opted out of the Medicare program effective on the following dates for a period of at least 2 years and are not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act. The provider's opt out effective date is:

Physicians and practitioner agree to provide medical services to the patient at Restore Wellness RGV. In exchange for the services, the patient agrees to make payments to the provider pursuant to a fee schedule which is available upon request. Patient also agrees, understands, and expressly acknowledges the following:

- Patient agrees not to submit a claim (or to request that the physicians or practitioner submit a claim) to the Medicare program with respect to the services, even if covered for Medicare part B.
- Patient is not currently in an emergency or urgent health care situation.
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the services.
- Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the services because payment is not made under the Medicare program, and other supplemental insurance plans may also deny reimbursement since a claim cannot be submitted to Medicare.
- Patient acknowledges that he or she has a right, as a Medicare beneficiary, to obtain Medicare covered items and services from physicians and practitioners who have not opted out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare covered services furnished by other physicians or practitioners who have not opted out.
- Patient agrees to be responsible, weather through insurance or otherwise, to make payment in full for the services, and acknowledges that physicians or practitioner will not submit a Medicare claim for the services and that no Medicare reimbursement will be provided.
- Patient understands that Medicare payment will not be made for any items or services furnished by the provider that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.

Patient technologist that a copy of this contract has been made available to him or her

Patient/Guardian Signature _____ Date _____

Stephen J. Martinez, PA-C _____ Date _____

Restore Wellness RGV Policies and Procedures

Thank you for giving us the opportunity to serve you! This document is designed to ensure that you understand our approach and treatment of your medical problems as well as the business procedures of Restore Wellness RGV. Please initial each paragraph to indicate your understanding of the policies/statements below. Please feel free to contact us if you have any questions.

1. **Initial_____Alternative and Complementary Medicine**: The provider and the allied personnel at Restore Wellness RGV have developed and provide an alternative and complementary approaches to conventional medical care. It is common for conventionally trained doctors to disagree with the treatment recommendations offered at Restore Wellness RGV.

2. **Initial_____ We treat patients, not lab values:** A distinctive feature of our alternative and complementary approach to your medical care is that we base your diagnosis and treatment primarily on your medical history and physical examination, rather than relying strictly on your blood test results. We do not routinely check estrogen and progesterone levels in the blood due to their unreliability and to the extreme variance which occurs during the menstrual cycle.

3. **Initial_____ Ours is not a quick-fix program:** The success of individuals who implement our treatment regimen is largely dependent upon their commitment to invest in the restoration of their health. The time it takes to obtain optimal health varies from person to person. It may take several months or even up to a year including ongoing treatment.

4. **Initial_____ Taking Charge of Your Health:** Patients who achieve the most significant improvements follow the recommendations of our provider, including bio-identical hormone supplement, eating recommendations, lifestyle modifications, vitamin and mineral supplementation, as well as weaning from psychiatric drugs. Regardless of how long it takes, our dedicated staff of professionals will continue to work with you to help you achieve your goal of optimal health.

5. **Initial_____ No Guarantees in Medicine:** We are committed to providing medical care designed to enable you to obtain and maintain health and wellness, however, there are no guarantees in medicine and results vary from patient to patient.

6. **Initial_____ Barriers to success on our treatment program:** Occasionally, patients may not respond well to our treatment regimen. Some patients have been overmedicated by their doctors, specifically with psychiatric drugs such as anti-depressants and sleep medications. Others are experiencing the adverse effects of dental mercury amalgams cams or root canals which may impair their bodies' ability to utilize hormones optimally. Other individuals get conflicting advice and opinions from other medical professionals, family, or friends, which leads them to discontinue treatment. Few people or physicians understand or appreciate the intricate connection between nutrition, allergies, the immune system and hormonal balance. Unless the patient is willing to comply with our recommendations and maintain close contact with our provider, they may fail to achieve optimal results. Some individuals, who are unable to follow through with the financial commitment required over the long term needed to purchase hormone prescriptions and/or vitamins, discontinue their treatment regimen.

7. **Initial_____ Insurance Not Accepted:** Restore Wellness RGV has always been a fee for service medical practice and does not accept insurance of any kind including Medicare, Medicaid, HMO, PPO, Tricare, Champus or indemnity insurance. Our provider has opted out of the Medicare program and is not a Tricare authorized provider. Therefore, all of our guests must accept the responsibility for payment of our services in full. Because we seek to prevent disease and promote wellness, many of our medical services would not be covered. We have always chosen to work directly with and for our patients, rather than indirectly through an insurance company. Although we do not work with insurance companies or stay versed on their coding requirements, we will provide you with the receipt that can be used if you choose to attempt to file claims for our services with your insurance company. The provider and staff of Restore Wellness RGV do not accept or file insurance claims and therefore cannot guarantee that the codes reflected on the receipt are the specific code required by the insurance companies. This information is only provided to assist you; the provider and staff of Restore Wellness RGV make no representation that these are the correct CPT codes.

8. **Initial_____ Fee for Service:** Restore Wellness RGV operates on a fee for service basis and payment for services is expected at the time services are rendered. For your convenience, we accept cash, checks, Master Card, Visa, Discover, and American Express. The person whose name is on the card must be present.

9. **Initial_____** Many guests of Restore Wellness RGV select Physicians Preference Pharmacy and Premier Research Labs vitamins to obtain prescription and supplements services. As a convenience to our guests, confidential communication between properly trained representatives of Restore Wellness RGV may assist Physicians Preference Pharmacy and to efficiently provide these services. By placement of my initials on this paragraph, I hereby consent to permit communication between employees of Restore Wellness RGV with Physicians Preference Pharmacy regarding my past and/or current prescription medication history as well as supplements and vitamin recommendations. I understand that my confidential health care information will remain carefully protected by the clinic and that this is a limited patient consent to disclose/discuss prescription medication and supplement/vitamin recommendations only.

10. **Initial_____ Research Studies**: I consent to allow anonymous data from my medical record to be used for research purposes.

Submit