



RESTORE  
WELLNESS

### Male 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:**

- ( ) I am sexually active.
- ( ) I want to be sexually active.
- ( ) I have completed my family.
- ( ) I have used steroids in the past for athletic purposes.

#### **Habits:**

- ( ) I smoke cigarettes or cigars \_\_\_\_\_ a day.
- ( ) I drink alcoholic beverages \_\_\_\_\_ per week.
- ( ) I drink more than 10 alcoholic beverages a week.
- ( ) I use caffeine \_\_\_\_\_ a day.

**Medical History**

Any known drug 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: \_\_\_\_\_

Other pertinent Information: \_\_\_\_\_

Medical Illnesses:

- |  |  |
|--|--|
| <input type="checkbox"/> High Blood Pressure                   | <input type="checkbox"/> Testicular or prostate cancer                             |
| <input type="checkbox"/> High cholesterol                      | <input type="checkbox"/> Elevated PSA  |
| <input type="checkbox"/> Heart Disease                         | <input type="checkbox"/> Prostate enlargement                                      |
| <input type="checkbox"/> Stroke and/ or heart attack           | <input type="checkbox"/> Trouble passing urine or take Flomax or Avodart           |
| <input type="checkbox"/> Blood clot and/ or a pulmonary emboli | <input type="checkbox"/> Chronic liver disease (hepatitis, fatty liver, cirrhosis) |
| <input type="checkbox"/> Hemochromatosis                       | <input type="checkbox"/> Diabetes  |
| <input type="checkbox"/> Depression/anxiety                    | <input type="checkbox"/> Thyroid disease   |
| <input type="checkbox"/> Psychiatric Disorder                  | <input type="checkbox"/> Arthritis   |
| <input type="checkbox"/> Cancer      (type): _____             |  |

Year: \_\_\_\_\_

I understand that if I began testosterone replacement with any testosterone treatment, including testosterone pellets, that I will produce less testosterone from my testicles and if stop replacement, I may experience a temporary decrease in my testosterone production. Testosterone Pellets should be completely out of your system in 12 months.

By beginning treatment, I accept all the risks of therapy stated herein and future risks that might be reported. I understand that higher than normal physiologic levels may be reached to create the necessary hormonal balance.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Today's Date

## Health Assessment for Men

Name: \_\_\_\_\_ Date: \_\_\_\_\_

E-mail: \_\_\_\_\_

Symptom (please check mark)	Never	Mild	Moderate	Severe
Decline in general well being	_____	_____	_____	_____
Fatigue	_____	_____	_____	_____
Joint pain/muscle ache	_____	_____	_____	_____
Excessive sweating	_____	_____	_____	_____
Sleep problems	_____	_____	_____	_____
Increased need for sleep	_____	_____	_____	_____
Irritability	_____	_____	_____	_____
Nervousness	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____
Depressed Mood	_____	_____	_____	_____
Exhaustion/ lacking vitality	_____	_____	_____	_____
Declining mental ability/focus/concentration	_____	_____	_____	_____
Feeling you have passed your peak	_____	_____	_____	_____
Feeling burned out/hit rock bottom	_____	_____	_____	_____
Decreased muscle strength	_____	_____	_____	_____
Weight Gain/ belly fat/ Inability to lose weight	_____	_____	_____	_____
Breast development	_____	_____	_____	_____
Shrinking testicles	_____	_____	_____	_____
Rapid hair loss	_____	_____	_____	_____
Decreased in beard growth	_____	_____	_____	_____
New migraine headaches	_____	_____	_____	_____
Decreased desire/libido	_____	_____	_____	_____
Decreased morning erections	_____	_____	_____	_____
Decreased ability to perform sexually	_____	_____	_____	_____
Infrequent or Absent Ejaculations	_____	_____	_____	_____
No results from E.D. Medications	_____	_____	_____	_____

### Family History

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

## 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 14<sup>th</sup>, 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](http://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 you 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



RESTORE  
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**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 caps 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.