The Hormone center

2100 Wharton Street-Suite 315, Pittsburgh, PA 15203
20399 Route 19-Suite 120, Cranberry Twp, PA 16066
Ph: 412-432-7909 Fax: 412-202-2304
INFO@HORMONECENTER.NET

SLEEP QUESTIONNAIRE

Date: _____

Patient Information

Name: _____ **Date of Birth:** _____ **Age:** _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Home Phone: _____**Cell Phone:** _____ **Email Address:** _____

How did you hear about us:

☐ **Compound Pharmacy**_____ **and name of pharmacy employee** _____

☐ **Current Patient** _____ ☐ **Doctor** _____

☐ **Event/Seminar** _____ ☐ **Hormone Center Employee** _____

☐ **Internet/Web site** _____ ☐ **Live/Work in Area**

Please note our 48 Hour Cancelation Policy**: **If you cancel or reschedule within 48 hours of your appointment or no show you will be charged a $75 fee.

How many hours do you typically sleep at night? _____ What time do you typically go to bed? _____

What time do you typically wake up? _____ Do you have trouble FALLING asleep? Y _____ N _____

Do you have trouble STAYING asleep? Y _____ N _____

What do you feel is interfering with your sleep? _____

Do you feel refreshed in the morning? Y ____ N ____

Please score the two factors below on a scale from 1 - 10 (1=None 10=Significant)

1. **My energy Level** _____
2. **My sense of Well Being** _____

Please complete questionnaire with consent forms and return to the center at least 2 days before your appointment via email (info@hormonecenter.net), fax (412-202-2304) or mail.

Past Medical History

Please list past medical conditions: _____

_____

_____

Past surgeries: _____

_____

_____

Medication Allergies: _____

_____

_____

Current medications (with dose): _____

_____

_____

_____

Previous medications (no longer taking): _____

_____

_____

Supplements and vitamins used on a regular basis: _____

_____

_____

- **Do you smoke?** □ Yes □ No **How much?** _____
- **Drink alcohol?** □ Yes □ No **How much?** _____
- **Do you exercise?** □ Yes □ No **How often?** □ Regular Basis □ Seldom
- **Date of most recent:** EKG _____ Stress Test_____ Lipid Panel _____

Bring results of most recent blood work within last year (if applicable)

- **Stress Level** (Please circle) High Moderate Low
- **List current stressors:** _____

_____

Women Only

- **Are you Pregnant?** ☐ Yes ☐ No
- **Do you plan to become pregnant within the next 12 months?** ☐ Yes ☐ No
- **Date of last Menstrual period?** _____ **Date of Menopause?** _____
- **Date of last Pap smear?** _____ **Completed by (Physician):**_____
- **Date of last Mammogram?** _____ **Completed by (Physician):** _____
- **Bone Density:** _____

Number of Pregnancies: _____ **Number of Live births:** _____ **Number of Miscarriages:** _____	**Stress Level:** _____ **Stressors:** _____ _____
PMS:_____ **Vaginal Complaints:** _____	

Men Only

Date of last prostate exam? _____ Completed by (Physician): _____

Date of last PSA test? _____ Completed by (Physician):_____

Family History

Uterine Cancer	(Y/N)	Who?	Age at Diagnosis?
Ovarian Cancer	(Y/N)	Who?	Age at Diagnosis?
Fibro Breast	(Y/N)	Who?	Age at Diagnosis?
Breast Cancer	(Y/N)	Who?	Age at Diagnosis?
Heart Disease	(Y/N)	Who?	Age at Diagnosis?
Osteoporosis	(Y/N)	Who?	Age at Diagnosis?
Colon Cancer	(Y/N)	Who?	Age at Diagnosis?
Thyroid Disorders	(Y/N)	Who?	Age at Diagnosis?
Other	(Y/N)	Who?	Age at Diagnosis?

Symptom List

Some of these Symptoms are purposely repeated because different hormone deficiencies may result in similar symptoms

COR

Do you ever have the following symptoms?	No Symptom Never	Few or Sometimes	Moderate or Regularly	Much Or Often	Always or Extreme
Poor tolerance to stress	[ ]	[ ]	[ ]	[ ]	[ ]
Anxiety with stress	[ ]	[ ]	[ ]	[ ]	[ ]
Low Blood pressure	[ ]	[ ]	[ ]	[ ]	[ ]
Tired during day	[ ]	[ ]	[ ]	[ ]	[ ]
Fatigue or Mood improved with sugar/sweets	[ ]	[ ]	[ ]	[ ]	[ ]
Salt Cravings	[ ]	[ ]	[ ]	[ ]	[ ]
Nausea	[ ]	[ ]	[ ]	[ ]	[ ]
Inflammatory disease (arthritis, etc.)	[ ]	[ ]	[ ]	[ ]	[ ]
Allergies to food or medications	[ ]	[ ]	[ ]	[ ]	[ ]
Brown spots or increased pigmentation	[ ]	[ ]	[ ]	[ ]	[ ]
Eczema, psoriasis or dandruff	[ ]	[ ]	[ ]	[ ]	[ ]
Sugar cravings	[ ]	[ ]	[ ]	[ ]	[ ]
Weak or tired when standing up	[ ]	[ ]	[ ]	[ ]	[ ]
Urinate often	[ ]	[ ]	[ ]	[ ]	[ ]
Low blood pressure	[ ]	[ ]	[ ]	[ ]	[ ]

MEL

Do you ever have the following symptoms?	No Symptom Never	Few or Sometimes	Moderate or Regularly	Much Or Often	Always or Extreme
Poor sleep	[ ]	[ ]	[ ]	[ ]	[ ]
Difficulty falling asleep	[ ]	[ ]	[ ]	[ ]	[ ]
Awakening at night	[ ]	[ ]	[ ]	[ ]	[ ]
Excessive pondering of problems at night	[ ]	[ ]	[ ]	[ ]	[ ]
Waking up tired (too little sleep)	[ ]	[ ]	[ ]	[ ]	[ ]

GH

Do you ever have the following symptoms?	No Symptom Never	Few or Sometimes	Moderate or Regularly	Much Or Often	Always or Extreme
Thinning Hair	[ ]	[ ]	[ ]	[ ]	[ ]
Thinning Skin	[ ]	[ ]	[ ]	[ ]	[ ]
Longitudinal lines on nails	[ ]	[ ]	[ ]	[ ]	[ ]
Premature wrinkling on face	[ ]	[ ]	[ ]	[ ]	[ ]
Loose or sagging skin	[ ]	[ ]	[ ]	[ ]	[ ]
Thinning lips	[ ]	[ ]	[ ]	[ ]	[ ]
Overweight	[ ]	[ ]	[ ]	[ ]	[ ]
Decreased muscle strength or tone	[ ]	[ ]	[ ]	[ ]	[ ]
Flabby muscles (Triceps of arm or	[ ]	[ ]	[ ]	[ ]	[ ]
other)	[ ]	[ ]	[ ]	[ ]	[ ]
Wrinkled hands	[ ]	[ ]	[ ]	[ ]	[ ]
Flabby dropping belly	[ ]	[ ]	[ ]	[ ]	[ ]
Often sick	[ ]	[ ]	[ ]	[ ]	[ ]
Easily exhausted	[ ]	[ ]	[ ]	[ ]	[ ]
Difficult to do daily required tasks	[ ]	[ ]	[ ]	[ ]	[ ]
Poor motivation for required tasks	[ ]	[ ]	[ ]	[ ]	[ ]
Constant tiredness	[ ]	[ ]	[ ]	[ ]	[ ]
Difficult to stay up late	[ ]	[ ]	[ ]	[ ]	[ ]
Difficult to recover after staying up late	[ ]	[ ]	[ ]	[ ]	[ ]
Need for a lot of sleep (over 10 hours)	[ ]	[ ]	[ ]	[ ]	[ ]
Low resistance to stress	[ ]	[ ]	[ ]	[ ]	[ ]

THY

Do you ever have the following symptoms?	No Symptom Never	Few or Sometimes	Moderate or Regularly	Much Or Often	Always or Extreme
Sensitive to cold	[ ]	[ ]	[ ]	[ ]	[ ]
Cold hands or feet	[ ]	[ ]	[ ]	[ ]	[ ]
Generalized fatigue	[ ]	[ ]	[ ]	[ ]	[ ]
Fatigue unless exercising	[ ]	[ ]	[ ]	[ ]	[ ]
Sleepy during day	[ ]	[ ]	[ ]	[ ]	[ ]
Distracted easily	[ ]	[ ]	[ ]	[ ]	[ ]
Poor motivation for required tasks	[ ]	[ ]	[ ]	[ ]	[ ]

Depression	[ ]	[ ]	[ ]	[ ]	[ ]
Headaches	[ ]	[ ]	[ ]	[ ]	[ ]
Water retention	[ ]	[ ]	[ ]	[ ]	[ ]
Constant swollen eyelids	[ ]	[ ]	[ ]	[ ]	[ ]
Swollen eyes in the morning	[ ]	[ ]	[ ]	[ ]	[ ]
Swollen calves/feet	[ ]	[ ]	[ ]	[ ]	[ ]
Difficulty losing weight despite dieting	[ ]	[ ]	[ ]	[ ]	[ ]
Constipation	[ ]	[ ]	[ ]	[ ]	[ ]
Bedwetting as a child	[ ]	[ ]	[ ]	[ ]	[ ]
Slow heart palpations	[ ]	[ ]	[ ]	[ ]	[ ]
Muscle cramps	[ ]	[ ]	[ ]	[ ]	[ ]
Carpal tunnel syndrome	[ ]	[ ]	[ ]	[ ]	[ ]
Stiff joints in the morning	[ ]	[ ]	[ ]	[ ]	[ ]
Joint pain worsens with cold	[ ]	[ ]	[ ]	[ ]	[ ]
Hoarse voice in the morning	[ ]	[ ]	[ ]	[ ]	[ ]
Dry skin (general/ feet or elbows)	[ ]	[ ]	[ ]	[ ]	[ ]
Slow growing or brittle nails	[ ]	[ ]	[ ]	[ ]	[ ]
Diffuse hair loss	[ ]	[ ]	[ ]	[ ]	[ ]
Muscle achiness or soreness	[ ]	[ ]	[ ]	[ ]	[ ]
Low body temperature	[ ]	[ ]	[ ]	[ ]	[ ]
Diminished sweating	[ ]	[ ]	[ ]	[ ]	[ ]
Tingling or numbness in extremities	[ ]	[ ]	[ ]	[ ]	[ ]
Hoarse voice	[ ]	[ ]	[ ]	[ ]	[ ]
Decreased hearing	[ ]	[ ]	[ ]	[ ]	[ ]
Course skin (rough skin)	[ ]	[ ]	[ ]	[ ]	[ ]

YEAST QUESTIONNAIRE

The total score for this section gives us the probability of yeast overgrowth being a significant factor in your case.

	Point Score
_____ Have you been treated for acne with tetracycline, erythromycin, or any other antibiotic for one month or longer?	50
_____ Have you taken antibiotics for any type of infection for more than two consecutive months, or in shorter courses over three times in a twelve-month period?	50
_____ Have you ever taken an antibiotic – even for a single course?	6
_____ Have you ever had prostatitis or vaginitis?	25
_____ Have you ever been pregnant?	5
_____ Have you taken birth control pills?	15
_____ Have you taken Corticosteroids such as Prednisone, Cortef, or Medrol?	15
_____ When you are exposed to perfumes, insecticides, or other odors or chemicals, do you experience wheezing, burning eyes, or any other distress?	15
_____ Are your symptoms worse on damp or humid days or in moldy places?	20
_____ Have you ever had a fungal infection, such as jock itch, athlete's foot, or a nail or skin infection, that was difficult to treat?	20
_____ Do you crave sugar or bread?	20
_____ Does tobacco smoke cause you discomfort (e.g. wheezing, burning eyes)?	10

Please add your points and record your Total Score _____

Female Symptoms (TO BE COMPLETED BY FEMALES ONLY)

E

Do you ever have the following symptoms?	No Symptom Never	Few or Sometimes	Moderate or regularly	Much or often	Always or extreme
Older looking than age	[ ]	[ ]	[ ]	[ ]	[ ]
Loss of attention to details	[ ]	[ ]	[ ]	[ ]	[ ]
Bleeding gums or poor teeth	[ ]	[ ]	[ ]	[ ]	[ ]
Fatigue throughout the day	[ ]	[ ]	[ ]	[ ]	[ ]
Poor recovery from physical exercise	[ ]	[ ]	[ ]	[ ]	[ ]
Depressed	[ ]	[ ]	[ ]	[ ]	[ ]
Poor memory	[ ]	[ ]	[ ]	[ ]	[ ]
Hot flashes	[ ]	[ ]	[ ]	[ ]	[ ]
Excessive sweating	[ ]	[ ]	[ ]	[ ]	[ ]
Dry eyes	[ ]	[ ]	[ ]	[ ]	[ ]
Dry vagina	[ ]	[ ]	[ ]	[ ]	[ ]
Pain during intercourse	[ ]	[ ]	[ ]	[ ]	[ ]
Pale skin	[ ]	[ ]	[ ]	[ ]	[ ]
Wrinkles around eye/forehead/mouth	[ ]	[ ]	[ ]	[ ]	[ ]
New body hair	[ ]	[ ]	[ ]	[ ]	[ ]
Dropping breasts	[ ]	[ ]	[ ]	[ ]	[ ]
Bladder infections	[ ]	[ ]	[ ]	[ ]	[ ]
Urinary incontinence	[ ]	[ ]	[ ]	[ ]	[ ]
First menstruation before 12 or after 15	[ ]	[ ]	[ ]	[ ]	[ ]
Depression before menstruation	[ ]	[ ]	[ ]	[ ]	[ ]

P

Do you ever have the following symptoms?	No Symptom Never	Few or Sometimes	Moderate or regularly	Much or often	Always or extreme
Irritable before menstruation (PMS)	[ ]	[ ]	[ ]	[ ]	[ ]
Swollen breasts/belly before menstruation	[ ]	[ ]	[ ]	[ ]	[ ]
Breast cysts	[ ]	[ ]	[ ]	[ ]	[ ]
Fibroids of uterus	[ ]	[ ]	[ ]	[ ]	[ ]
Endometriosis	[ ]	[ ]	[ ]	[ ]	[ ]
General irritability	[ ]	[ ]	[ ]	[ ]	[ ]
Generalized anxiety	[ ]	[ ]	[ ]	[ ]	[ ]

T

Do you ever have the following symptoms?	No Symptom Never	Few or Sometimes	Moderate or regularly	Much or often	Always or extreme
Too emotional	[ ]	[ ]	[ ]	[ ]	[ ]
Too rigid	[ ]	[ ]	[ ]	[ ]	[ ]
Poor strength	[ ]	[ ]	[ ]	[ ]	[ ]
Low libido (sex drive)	[ ]	[ ]	[ ]	[ ]	[ ]
Difficulty achieving orgasm	[ ]	[ ]	[ ]	[ ]	[ ]
Poor muscle tone	[ ]	[ ]	[ ]	[ ]	[ ]
Excessive fat	[ ]	[ ]	[ ]	[ ]	[ ]
Cellulite	[ ]	[ ]	[ ]	[ ]	[ ]
Varicose veins	[ ]	[ ]	[ ]	[ ]	[ ]
Hemorrhoids	[ ]	[ ]	[ ]	[ ]	[ ]
Bruising easily	[ ]	[ ]	[ ]	[ ]	[ ]

Male Symptoms (TO BE COMPLETED BY MALES ONLY)

T

Do you ever have the following symptoms?	No Symptom Never	Few or Sometimes	Moderate or regularly	Much or often	Always or extreme
Older looking than age	[ ]	[ ]	[ ]	[ ]	[ ]
Loss of feeling of well-being	[ ]	[ ]	[ ]	[ ]	[ ]
Loss of attention to details	[ ]	[ ]	[ ]	[ ]	[ ]
Poorly motivated	[ ]	[ ]	[ ]	[ ]	[ ]
Excessive fat	[ ]	[ ]	[ ]	[ ]	[ ]
Fatigue	[ ]	[ ]	[ ]	[ ]	[ ]
Loss of muscle mass or strength	[ ]	[ ]	[ ]	[ ]	[ ]
Poor recovery from physical activity	[ ]	[ ]	[ ]	[ ]	[ ]
Poor endurance	[ ]	[ ]	[ ]	[ ]	[ ]
Poor motivation for required tasks	[ ]	[ ]	[ ]	[ ]	[ ]
Depression	[ ]	[ ]	[ ]	[ ]	[ ]
Passive	[ ]	[ ]	[ ]	[ ]	[ ]
Decreased memory	[ ]	[ ]	[ ]	[ ]	[ ]
Irritable	[ ]	[ ]	[ ]	[ ]	[ ]
Too emotional	[ ]	[ ]	[ ]	[ ]	[ ]
Rigid	[ ]	[ ]	[ ]	[ ]	[ ]
Hair loss	[ ]	[ ]	[ ]	[ ]	[ ]
Poor beard growth	[ ]	[ ]	[ ]	[ ]	[ ]
Scarce body hair	[ ]	[ ]	[ ]	[ ]	[ ]
Bleeding gums or poor teeth	[ ]	[ ]	[ ]	[ ]	[ ]
Dry eyes	[ ]	[ ]	[ ]	[ ]	[ ]
Pale skin	[ ]	[ ]	[ ]	[ ]	[ ]
Wrinkles on face/ palm of hand	[ ]	[ ]	[ ]	[ ]	[ ]
Poor endurance	[ ]	[ ]	[ ]	[ ]	[ ]
Varicose veins	[ ]	[ ]	[ ]	[ ]	[ ]
Hemorrhoids	[ ]	[ ]	[ ]	[ ]	[ ]
Easy bruising	[ ]	[ ]	[ ]	[ ]	[ ]
Poor wound healing	[ ]	[ ]	[ ]	[ ]	[ ]
Poor muscle tone (triceps or other)	[ ]	[ ]	[ ]	[ ]	[ ]
Joint pains	[ ]	[ ]	[ ]	[ ]	[ ]
Intense sweating	[ ]	[ ]	[ ]	[ ]	[ ]
Urination problems	[ ]	[ ]	[ ]	[ ]	[ ]
Urinary incontinence	[ ]	[ ]	[ ]	[ ]	[ ]
Loss of urine after urination	[ ]	[ ]	[ ]	[ ]	[ ]
Swollen prostate	[ ]	[ ]	[ ]	[ ]	[ ]
Poor libido (sex drive)	[ ]	[ ]	[ ]	[ ]	[ ]
Difficulty achieving orgasm	[ ]	[ ]	[ ]	[ ]	[ ]
Decreased ability to maintain erection	[ ]	[ ]	[ ]	[ ]	[ ]
Decreased erections frequency of firmness	[ ]	[ ]	[ ]	[ ]	[ ]

2100 Wharton St-Suite 315, Pittsburgh, PA 15203 20399 Route 19-Suite 120, Cranberry Twp, PA 16066 Phone: 412-432-7909 Fax: 412-202-2304

POLICIES AND PROCEDURES

In the interests of ensuring a smooth process for patient care, please review the following information:

To maximize the time with the provider, ARRIVE 15 minutes prior to your appointment to take vitals and complete paperwork. Out of respect for all of our patients' time, if a patient is late the visit may be shortened to accommodate subsequent scheduled patients. Longer appointment times are available with the provider (please contact our office for details).

General Office Hours

Monday 8:30 am – 4:00 pm
Tuesday 9:30 am - 5:00 pm
Wednesday 8:30 am – 4:00 pm
Thursday 8:30 am - 4:00 pm
Friday 9:30 am – 3:30 pm **Southside location only*

****(Cranberry location open until 5:30 Monday - Thursday)***

CANCELLATION POLICY: If a patient cancels or reschedules within 48 hours of the appointment or fails to keep the appointment, there will be a $75 fee.

PATIENT COMPLIANCE: All patients agree to schedule office visits at intervals recommended by the provider who reserves the right to withhold refilling of medications if patients do not follow the recommended office visit/appointment schedule.

SUBMITTING TO INSURANCE: Although The Hormone Center providers do not participate with any insurance programs patients receive itemized invoices with insurance claim codes for possible reimbursement. Since the providers have opted out of all **Medicare/Tricare** programs, **patients are NOT permitted to submit claims to any Medicare** or Tricare programs for reimbursement.

QUESTIONS FOR THE PROVIDERS: To ensure timely response, questions for all providers should be communicated through the registered nurse. Please email our nurse (nurse@hormonecenter.net) or call the office during regular office hours.

PRESCRIPTION REFILLS: Patients should first contact their pharmacist who will submit a request to our office. Allow 48 hours for all refill requests. You may request prescription refills through our office via email prescription@hormonecenter.net or phone. **Requests made after 1:00 pm on Thursday will be reviewed on Monday.**

SUPPLEMENT ORDERS: Our preferred method of receiving supplement orders is via email at supplement@hormonecenter.net or at the next visit. Phone orders can be placed during regular office hours Monday through Friday. **Orders placed after 3:00 p.m. on Friday will be handled on Monday.**

I have read, understood and agree to abide by the above policies and procedures. This consent form is valid until all or part is revoked in writing.

_____ _____ _____

Patient Name (Printed) Patient Signature Date

The Hormone Center
Skin Beautiful Medical Spa

CONSENT FOR TREATMENT

I request treatment by The Hormone Center (THC), Skin Beautiful Medical Spa (SBMS)and/or SB Medical Weight Loss ("SBMWL") physician or designee. I understand that I have the right, as a patient, to be informed about my condition and the recommended treatment to be used so that I can make an informed decision whether or not to undergo the treatment after I have been told both the potential benefits, risks, and hazards involved.

Some treatments used at THC/SBMS/SBMWL are considered "off label" use by the Food and Drug Administration. In the United States, the regulations of the FDA permit physicians to prescribe or use approved medications for other than their intended indications. This practice is known as "off-label use" or "unlabeled uses". Such uses are not indicative of inappropriate usage but are legal and common. To access for information on off-label uses, please visit the FDA's website: www.fda.gov/eder

I agree to comply with any pre-treatment, treatment and post treatment instructions as indicated by the medical provider. I agree to immediately report any adverse reaction or problem to THC/CFF/SBMS/SBMWL.

I understand that THC/SBMS/SBMWL medical providers are not my Primary Care Provider (PCP). I understand that I will need a PCP to monitor any ongoing medical problems.

I understand that THC/SBMS/SBMWL does not accept insurance company payments for possible treatment nor does THC/CFF/SBMS/SBMWL coordinate document submission for potential insurance company reimbursement. Any attempt to be reimbursed by an insurance company is solely the patient's responsibility.

Although THC/SBMS/SBMWL is not subject to the Health Insurance Portability and Accountability Act (HIPAA), we follow HIPAA guidelines regarding patient privacy. We will not release your health information without your consent unless subpoenaed by a court of law.

I have read and understand this consent form and agree to its terms. I understand that payments for procedures at THC/SBMS/SBMWL are non-refundable and that it is possible that these procedure treatments may be of little or no help at all. I have had the opportunity to ask any questions about the treatment including: outcomes, risks, complications and alternative therapies. I further understand that THC/SBMS/SBMWL cannot guarantee the results and will not hold its employees responsible for the individual results of the treatment that I have requested. I also understand that any follow-up treatments required will be at my own expense. This consent form is valid until all or part is revoked in writing.

_____
Patient Name (Printed)

_____ _____
Patient Signature Date Provider Signature Date

The Hormone Center &
Skin Beautiful Medical Spa
2100 Wharton St-Suite 315, Pittsburgh, PA 15203
20399 Rt 19-Suite 120 Pittsburgh, PA 16066
Phone: 412.432.7909 • Fax: 412.202.2304

Payment, Blood Draw and Photo Consent Form

Patient Name: _____ **Date of Birth**: _____

PAYMENT POLICY
I understand that all fees are due at the time of service, unless otherwise specified by the provider.

I understand that there is a 48 hour cancellation policy that I will be charged $75 for either not showing for an appointment **or** for canceling/rescheduling an appointment within 48 hours of said appointment.

BLOOD DRAW CONSENT
In the instance that my provider is accidentally exposed to my bodily fluids (i.e., needle stick), I consent to have my blood drawn and tested for HIV and Hepatitis. The results of this testing will remain confidential as required by law.

PHOTOS
By checking one of the boxes below I give the provider permission to use my photographs in the following manner:

☐ I only want my photos used in the medical chart
Fibromyalgia and Bio-Identical Hormone patients: this is only a face shot for our photo recognition program in our patient system.

☐ I do not want any photos taken
Medspa patients: I understand that by not having any photos taken I will not have documentation of before and after results of my treatment.

☐ Unrestricted use of photographs
This may include lectures, before and after pictures, website, etc.

COMMUNICATION VIA EMAIL AND/OR TEXT
By checking the boxes below I consent to communication/notification of the following:

☐ Medical information specific to my medical history, diagnosis, treatments and/or recommendations

☐ Appointment reminder

☐ Receive monthly specials for Skin Beautiful Medical Spa

For Email Notifications enter Email Address: _____@_____.____

For Text Notifications enter **CELL PHONE #**_____-_____-_____ ***Choose carrier below***
☐ Verizon ☐ AT&T ☐ Cingular ☐ Sprint ☐ T-Mobile

This consent form is valid until all or part is revoked in writing.

_____ _____ _____
Patient's Name **Signature** (Parent or Guardian if under 18) **Date**

PATIENT INFORMATION & CONSENT

_____ _____ _____

Last Name **First Name** **Date of Birth**

_____ _____

Address **Apt #**

_____ _____ _____

City **State** **Zip Code**

_____ _____ _____

Home # **Work #** **Cell #**

Name of emergency contact_____ **Relationship**_____ **Phone** _____

INSURANCE ***(****please check one of the following)*

Do you have: □ Medicare □Tricare □Neither

The providers have opted out of all **Medicare/Tricare** programs, patients are **NOT** permitted to submit claims to any Medicare/Tricare program for reimbursement.

If you answered checked Medicare or Tricare do you have a secondary insurance? ___Yes ___No

---

HIPAA Acknowledgement

I hereby acknowledge that I have been made aware that the physicians have a privacy policy in place in accordance with the Health Insurance Portability Act of 1996 (HIPAA). As a patient, I acknowledge that the physician or designee has a privacy policy in effect and has made this policy available to me. I am entitled to an additional copy of the privacy policy if I desire.

☐ **I authorize the physician or designee to discuss my medical care and treatment with the following people (spouse, children, parent, etc.)**

1. _____ 2. _____

3. _____ 4. _____

I understand this form is valid until all or part is revoked in writing.

X_____ _____

Patient signature or guardian for the minor patient Date

The Hormone center

Naturopath Consent

I understand that I am here about nutrition and better health practices and that I will be offered information about food supplements and herbs as a guide to general good health and this is considered a personal ministry and spiritual counseling. I understand that I am taking full responsibility for all decisions concerning my health and hereby release Jeanie Anderson N.D. and The Hormone Center in their service from any liability whatsoever.

I fully understand that Jeanie Anderson N.D. is not a medical doctor or practitioner and I am not here for medical-diagnostic purposes or treatment procedures. I am not on this visit or any subsequent visit as an agent for federal, state, or local agencies or on a mission of entrapment or investigation.

The services performed by Jeanie Anderson N.D. is at all times restricted to the subject of nutrition matters intended for the maintenance of the best possible state of nutritional health and do not involve the diagnosing, treatment or prescribing of remedies for disease.

I understand that harmonic quads (zappers) have been demonstrated by research to kill some parasites, that zappers have not been approved by the AMA for use on humans, that no medical claims are made or implied by the manufacturer or by Jeanie Anderson and The Hormone Center in their services and that zappers should not be used by people with pacemakers or other electrical devices that may be implanted in the body.

_____

Printed Name

_____ _____

Signature **Date**