The Hormone center

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20399 Route 19-Suite 120, Cranberry Twp, PA 16066
Ph: 412-432-7909 Fax: 412-202-2304 Info@HormoneCenter.net

TRIGGER POINT QUESTIONNAIRE

Patient Information

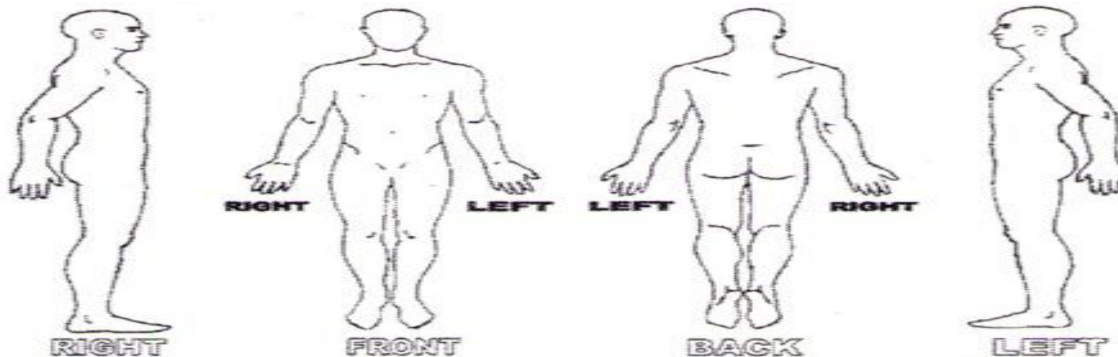
Name: ________________________________ **Date of Birth:** _____________

Address: _______________________________ **City:** _____________ **State:** _____ **Zip** ______

Home Phone ____________ **Cell Phone** _____________ **Email** _______________________

If you cancel/reschedule within 48 hours of your appointment or no show you will be charged a $75 fee.

Please indicate (by shading in) where you are experiencing pain (or other symptoms):



Medical History: ____

____

____

Do you have a history of bleeding problems or excessive bruising? ______Yes ______ No
Do you have DIABETES MELLITUS? ______ Yes ______ No
Do you currently have active infections or illnesses? ______ Yes ______ No
Please identify any surgeries that you have undergone and when: ___________________________

____

Medication Allergies: ____

____

Do you have a known allergy to Lidocaine? ______ Yes ______ No
Current medications (with dose): ____

____

Are you taking ASPIRIN or NSAIDs (e.g. Ibuprofen)? ______ Yes ______ No
Are you taking BLOOD THINNERS (e.g. Coumadin, Eliquis, Plavix, etc.)? ______ Yes ______ No
Are you currently taking STEROIDS (e.g. Prednisone, etc.)? ______ Yes ______ No
Supplements and vitamins taken on a regular basis: ______________________________________

____

Is there any other information you would like to share with the provider? ________________________

____

____

Patient Signature Date

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).

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

CONSENT FOR TREATMENT

I request treatment by The Hormone Center (THC), Skin Beautiful Medical Spa (SBMS) and/or by their physician/medical provider 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 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/SBMS.

I understand that THC/SBMS 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 does not accept insurance company payments for possible treatment nor does THC/SBMS 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 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 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

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 & Monthly Specials

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**

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