The Hormone center

20399 Route 19, Suite 120
Cranberry Twp, PA 16066

2100 Wharton St, Suite 315
Pittsburgh, PA 15203

HEALTH INFORMATION FORM

Name:_____ DOB:_____

Please list current medications/supplements:

Medication Name	Dose	Frequency	Started (mm/yy)

List allergies that you know/suspect and your reaction:

Foods:_____

Medicines:_____

Environmental:_____

Metals:_____

Have you ever been diagnosed with any of the following:

	Alzheimer's		colon		hay fever		liver		slow learner
	anemia		constipation		hearing loss		lungs		spine/back
	arthritis		diabetes		heart		nerves		spleen
	asthma		digestion		hemorrhoids		ovaries		stomach
	bladder		edema		high blood pressure		pancreas		throat
	bleeding		epilepsy		hyperglycemia		parasites		thyroid
	breast		eye problems		hypoglycemia		PMS		tumor
	cancer		fainting		kidneys		prostate		weight
	circulation		gall bladder		low blood pressure		skin		

Have you had any surgeries?_____

Body parts removed? (circle) Tonsils | Adenoids | Gall Bladder | Appendix | Uterus | Ovaries | Other: _____

Body parts transplanted?_____

Energy Level: (Circle the following answer)

Good	Very Good	Tired after Eating	Moderate	Tired During the Day	Low	Other:

Sleeping Habits:

How many hours do you sleep per night?_____ Do you wake feeling rested?_____

Do you have a difficult time falling asleep?_____

Do you wake up frequently during the night?_____

If so, do you wake up at the same time every night?_____

Do you have a difficult time falling back to sleep?_____

Eating Habits:
What do you eat for:

Breakfast:_____

Lunch:_____

Dinner:_____

Between Meals:_____

Before Bed:_____

Every couple hours:_____

What foods do you crave? (circle) Sweet | Salty | Spicy | Bitter | Sour | Chocolate | Ice | Soda

Other:_____

Do you use sweeteners? (circle)
Saccharin/Sweet'n Low | Aspartame/Equal/Nutrasweet/Spoonful | Sucralose/Splenda |
Other:_____

How much water do you drink/day?_____ Drink with meals?_____
Do you drink coffee?_____ How many cups/day?_____

What kind of water?

	well water		spring water		bottled spring water
	distilled		bottled distilled		city tap
	water softener		reverse osmosis		other:

Urination: (circle all that apply)
Kidney Stones | Bladder Infections | Frequency | Urgency | Loss of Bladder Control | Irritations

Other:_____

Bowel Movements:
How often do you move your bowels per day? (circle) 1x | 2x | 3x |

Other:_____

Color of stool?_____

Texture of Stool:(circle) Hard | Dry | Watery | Soft | Stringy | Not formed | Formed and Easy to Pass
Formed and Not Easy to Pass |

Other:_____

Exercise Habits:

Do you exercise regularly? _____
If yes, how often?_____ What type of exercise?_____

Have you had any: (please explain)

fractures:		serious falls:	
injuries:		car accident:	
drug/alcohol abuse:		stress:	
anxiety:		depression:	

Women - have you experienced any: (please explain)

painful periods:		vaginal discharge:		PMS:	
light bleeding:		heavy bleeding:		miscarriage:	
menopause:		hysterectomy:		endometriosis:	
gential pain/sores:		sexual difficulty:		breast issues	

Men - have you experienced any: (please explain)

swollen prostate:		frequent urination:		sexual difficulty:	
jock itch:		Other:			

Children- have you experienced any: (please explain)

ADD:		ADHD:		anger:	
autistic:		overly active:		under active:	
emotional:		learning impaired:		frequent ear aches:	
tubes in ears:		first child:		middle child:	
Other:					

Please list your Health Concerns in Order of Importance to You:

_____

_____

_____

_____

_____

_____

POLICIES, PROCEDURES, & CONSENTS

Below is an explanation of our policies, procedures, and consent for treatment that will be followed as a patient in our practice. As a patient of our practice you must abide by all of our policies and procedures.

Please review each item:

- I request treatment by The Hormone Center (THC), Skin Beautiful Medical Spa (SBMS) and/or How To Health ("HTH") physician or designee. As a patient, I understand that I have the right to be informed about my condition and the recommended treatment/s including potential benefits and risks so that I can make an informed decision whether or not to undergo the treatment.

- I understand that the Providers at THC/SBMS/HTH, are not my Primary Care Provider (PCP). I understand that I will need a PCP to monitor any ongoing medical problems.

- Some treatments used at THC/SBMS/HTH 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. At times, this practice does recommend "off-label use" or "unlabeled uses" for medications. 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 physician or her designee. I agree to immediately report any serious adverse reaction or problem to THC/SBMS/HTH.

- I understand that misuse or the failure to follow treatment protocols as prescribed by THC/SBMS/HTH (noncompliance) can result in the dismissal of myself as a patient of the practice.

- I agree to update THC/SMBS/HTH with any demographic or medical health information in a timely manner to avoid disruption of care.

- I 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.

- 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.

- To ensure timely response, questions for all provider between scheduled appointments should be communicated through the clinical staff by phone or through the patient portal.

- Medication refills will be processed in 48-72 business hours from the time of the request. At the time of the request please provide the name, dose, quantity, and pharmacy information to ensure a timely and efficient response.

- Refill requests made after Thursday at 1PM will be received on Monday as the office is closed on Fridays.

- I understand that THC/SBMS/HTH does not accept insurance company payments for possible treatment nor does THC/SBMS/HTH coordinate document submission for potential insurance company reimbursement. Any attempt to be reimbursed by an insurance company is solely the patient's responsibility. Patients will receive itemized invoices with insurance claim codes for possible reimbursement.

- Our providers have opted out of all Medicare/Tricare programs. Therefore, patients are NOT permitted to submit claims to any Medicare or Tricare programs for reimbursement.

- I give my consent for THC/SBMS/HTH to use my photographs for medical documentation/identification purposes.

- 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.

I have read and understand this consent form and agree to its terms. I understand that payments for procedures at THC/ SBMS/HTH 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/HTH 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

_____

Relationship to Patient (if another than patient)

HIPAA - PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and discloser of protected health information about you for treatment, payment, and health care options. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made based on your prior Consent.

The Patient Understands that:

- Protected health information may be disclosed or used for treatment, payment, or health
- The Practice has a Notice of Privacy Practices and the patient has the opportunity to review this notice
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information but the Practice does not have to agree to the restrictions
- The patient may revoke this consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent.

I authorize THC/SBMS/HTH staff to discuss my medical care and treatment with the following people:

1._____ 2._____

3._____ 4._____

_____

Printed Name: Patient or Representative

_____ _____

Signature Date

_____

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Natural Health 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**