LoTurco Chiropractic PLLC

Hormone Replacement Therapy

Patient Name:

_____

Address:

_____

Apt_____ City_____ State_____

Zip_____

Home Phone ( ) _____ Cell Phone ( ) _____

Date of Birth _____/_____/_____ Age_____ Sex_____

Email:_____

Emergency Contact_____Phone Number: _____

Medical History

Primary Care Physician: _____Phone: _____

List any medical problems:

_____

List all prior hospitalizations, surgeries (include dates):

_____

List any medications you are taking & dosage:

_____

_____

Do you have **allergies** to medication? Yes No If yes, please list:

_____

Do you use? tobacco____ alcohol____ IV drugs ____

Which of the following conditions are you currently being treated or have been in the past:

Heart Disease/Murmur/Angina		Shortness of Breath	Glaucoma	Diabetes	High Cholesterol
Asthma	Seizure	Kidney/Bladder	High Blood Pressure		Lung Problems
Stroke	Liver Problems	Low Blood Pressure	Sinus	Headaches	Arthritis
Heartburn	Tonsillitis	Cancer	Depression	Anxiety	Anemia
Ulcers	Thyroid	Seasonal Allergies			

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Please describe any current/past medical treatment not listed above :_____

_____

Please circle any Family history:

Anemia Cancer	Diabetes	Glaucoma	Heart Disease	High Blood Pressure
HIV Disease/Aids	Mental Illness	Depression	Stroke	Other: _____

Males: Urogenital History

Have you had any kidney, bladder, or prostate infections within the last 12 months? Yes No

Has the force of your urination decreased? Yes No

Do you feel burning discharge from penis? Yes No

Do you feel pain or burning with urination? Yes No

Any blood in your urine? Yes No

Do you have any problems emptying your bladder completely? Yes No

Any difficulty with erection or ejaculation? Yes No

Any testicle pain or swelling? Yes No

Date of Colonoscopy? _____ Date of last prostate and rectal exam? _____

Females: Gynecological History

How many times have you been pregnant? _____ Date of last Pap Smear: _____

Have you had an abnormal Pap Smear? Yes No Diagnosis:_____

Follow up?:_____

Have you ever had a sexual transmitted disease? Yes No Last Menstrual Cycle: _____

Hormone Replacement Therapy

Date of Last Mammogram: _____ Results:_____
Have you ever had a breast biopsy? Yes No Biopsy Result: _____
Menopause? Yes No Hysterectomy? Yes No

CONSENT FOR TREATMENT:

I, the patient named above, do request and consent to have LoTurco Chiropractic PLLC, Hormone Replacement Therapy and their employees, evaluate and treat the above patient for medical complaints and illnesses. This includes, but is not limited to, taking of medical information, evaluation by physical examination, obtaining of bodily fluids for laboratory testing, the administration of medications for treatment, and any other treatment or evaluation that may be necessary. If, at any time, I do not wish to have these services rendered, I may state so and they will not be provided, but an AMA form may need to be signed by the patient. All of my information will remain confidential. I acknowledge that I have been offered a copy of LoTurco Chiropractic PLLC, Hormone Replacement Therapy Notice of Privacy Practices.

CONSENT FOR TEST INFORMATION:

□ by checking this box I agree to be contacted by phone and voicemail may be left, and/or by email by our staff regarding your medical treatment and information.

Phone # ____ - ____ - _____ Email:

_____

By signing below, I hereby certify that to the best of my knowledge all the information I have provided on this form is complete, true and accurate. I understand this agreement is between I, the patient and LoTurco Chiropractic PLLC, Hormone Replacement Therapy.

Patient Initials: ____

LoTurco Chiropractic PLLC

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Patient Name _____

Signature _____ Date _____/_____/___

Check all that apply:

Male symptoms of low testosterone:

Difficulty concentrating	☐ Yes ☐ No
Moodiness	☐ Yes ☐ No
Depression	☐ Yes ☐ No
Weight gain	☐ Yes ☐ No
Decreasing sex drive	☐ Yes ☐ No
Increasing fatigue	☐ Yes ☐ No
Decreasing energy	☐ Yes ☐ No
Daytime sleepiness	☐ Yes ☐ No
Poor sleep habits	☐ Yes ☐ No
Erectile dysfunction	☐ Yes ☐ No

Female symptoms of hormone imbalance:

Hot flashes	☐ Yes ☐ No
Night sweats	☐ Yes ☐ No
Mood swings	☐ Yes ☐ No
Depression	☐ Yes ☐ No
Weight gain	☐ Yes ☐ No
Trouble sleeping	☐ Yes ☐ No
Decreased mental clarity	☐ Yes ☐ No

Patient Initials: ____

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Less interest in sex	☐ Yes ☐ No
Pain during intercourse	☐ Yes ☐ No
Vaginal dryness	☐ Yes ☐ No
Heavy vaginal bleeding	☐ Yes ☐ No
Breast tenderness	☐ Yes ☐ No
Acne	☐ Yes ☐ No
Thin and/or dry skin	☐ Yes ☐ No
Excessive hair on face and arms	☐ Yes ☐ No
Thinning hair on head	☐ Yes ☐ No

Notice of Privacy Practices and Patient Rights

The use and Disclosure of Protected Health Information.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. *Please review it carefully*. We are required by law to maintain the privacy of your health facts and to provide you with the notice of our legal duties and privacy practices. We must follow the terms of the notice in effect right now, but *we reserve the right to change the terms*. If there is a change, we will provide you with a written, revised notice upon request. As a patient of ours, facts about you must be used and disclosed to other parties for treatment, payment and health care operations. These uses and disclosures require your consent, and include, *but are not limited to the following information: A release of information contained in financial and/or medical records; Diseases spread person to person, such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS); Drug and/or alcohol abuse; Psychiatric diagnosis*

Patient Initials: ____

Hormone Replacement Therapy

and treatment records; Laboratory test results; Medical history; Treatment progress; Data from the OASIS data set (home health); Any other related facts.

We may release the above to:

1. Your insurance company, Medicare, Medicaid, or any other person who will pay your bill for services or who will process your bill for services in order for us to receive payment;
2. Any person from a program or an insurance company, who performs billing, quality and risk management tasks, such as insurance auditors and state Risk Management; Any hospital, nursing home, or other health care facility where you may have done testing done or to which you may be admitted; Any assisted living or personal care facility where you live; Any doctor providing your care; Family members and other people who are part of your plan for service, in such programs as CSHP, EPSDT, home health, hospice, etc.; State and/or Federal agencies acting on behalf of programs, Medicare and/or Medicaid, including state surveyors or auditors for programs such as CSHP, EPSDT, PCS, WIC, STD/HIV, home health, hospice, etc.; Other health care people to start treatment.

We may contact you to:

1. Provide appointment reminders or news about other health programs we provide;
2. Raise funds or donate items for our business.

We are allowed to use or disclose facts about you without consent in the following situations:

1. In emergency treatment situations, if we try to obtain consent as soon as possible after treatment;
2. Where significant barriers to communicating with you exist and we determine that the consent is clearly inferred from the situation;

Patient Initials: ____

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3. Where we are required by law to provide treatment and we are unable to obtain consent;
4. Where the use or disclosure is required by law;

5. For certain public health activities, such as reporting births, deaths, injuries, diseases, etc.; 255 Union blvd Suite 330 Lakewood, CO 80228 720-476-5121 OR the respected partnered address of LoTurco Chiropractic PLLC, Hormone Replacement Therapy;
6. Where we reasonably believe you are a victim of abuse, neglect, or domestic violence to a government agency authorized to receive abuse, neglect or domestic violence reports;
7. Health care oversight activities;
8. Certain legal administrative proceedings;
9. Certain law enforcement purposes;
10. To coroners, medical examiners and funeral directors in certain situations (home health, hospice, etc);
11. For organ, eye or tissue donation purposes (home health, hospice, etc.);
12. For certain research purposes;
13. To avoid a serious threat to health and safety;
14. For specialized government functions, including military and veterans' activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutional and custodial situations;
15. For Worker's Compensation purposes.

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We are allowed to use or disclose facts about you without consent or authorization (provided you are informed in advance and given the chance to agree to, restrict or forbid) to disclose information for the stated below situations:

1. The use of a directory of people served by us (clinic schedules, patients schedules);
2. To a family member, friend or other person you choose who may assist in your care or payment for care. Other uses and disclosures will be made only with your written approval. That approval may be withdrawn in writing at any time, except in limited situations.

Patient Rights: You have the right, subject to certain conditions, to:

1. Request restrictions on certain uses and disclosures of facts about you by filling out our Request form. However, we are not required to agree to the requested restrictions.
2. Receive confidential communication of protected health data by giving us another address or means of receiving health data.
3. Inspect and copy protected health data by filling out our request form.
4. Amend protected health data by filling out our form.
5. Receive a list of disclosures made of your protected health data by filling out our request form.
6. Obtain a paper copy of this notice upon request, if you agreed to this notice by email, fax, or website.
7. Complaints: You may complain to us and the Secretary of the U.S. Department of Health and Human Services if you believe that your privacy rights have been violated. There will be no retaliation against you for filing a complaint. *The complaint must be filed in writing with us and must state the specific incident(s)* including the date, what happened and details of the incident. By signing below, you are stating you understand and agree to all the above statements.

Patient Initials: ____

Hormone Replacement Therapy

I acknowledge that I have received a copy of the Provider's Notice of Privacy Practices with the effective date of January 1, 2021

Name of Patient:_____DOB:_____Date:_____

Signature of patient/representative _____
Relationship to patient:_____

Documentation of Good Faith Efforts

To obtain a patient's acknowledgement that they received the provider's Notice of Privacy Practices ***(For use when acknowledgment cannot be obtained from the patient.)***

The patient presented to the office/hospital on _____and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- ❑ Patient refused to sign.
- ❑ Patient was unable to sign or initial because: _____
- ❑ The patient had a medical emergency, and an attempt to obtain the

Patient Initials: ____

acknowledgment will be made at the next available opportunity.

❑ Other reason: _____

Signature of Employee Completing Form: _____

Date Signed: _____ Acknowledgement of Receipt of Privacy Notice/Good Faith Efforts**Updated Jan 2021**

TESTOSTERONE MEDICATION USE AGREEMENT

This Testosterone Medication Use Agreement (the "Agreement"), made and entered as of _____ _____, 2021, by and between _____ (the "Patient"), and LoTurco Chiropractic PLLC, Hormone Replacement Therapy a Colorado Limited Liability Company ("LTCG-HRT"). The Patient hereby agrees and expressly authorizes LTCG-HRT to secure a medical laboratory, physician/medical doctor ("Treating Physician") and dispensing pharmacy (collectively " Medical Providers") to provide the Patient diagnostic testing, medical care and prescribed pharmaceuticals based on the completed and accurate medical history form ("Medical History Form") provided by the Patient, and any laboratory diagnostic tests obtained through LTCG-HRT, pursuant to and subject to the terms and conditions of this Agreement. The Patient understands that the Medical History Form becomes the property of LTCG-HRT, and the Patient will have continuing access and the right to copy and retain all portions of the medical record, subject to applicable law.

MEDICATION USE OF TESTOSTERONE

Patient Initials: ____

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1. **Competency.** The Patient hereby understands that testosterone, anti-estrogen, and human chorionic gonadotropin therapy for adults involves the use of medications that may be approved for a different purpose in an effort to obtain an objective of medical treatment. The Patient is a competent adult and permitted by law in the state of residence to receive the medication(s) requested for personal and therapeutic purposes. The Patient acknowledges he/she has been fully informed by appropriately trained health care personnel and understands the risks, benefits, and possible side effects of the prescription drug(s) requested.

2. **Purpose.** The Patient executes this agreement with the complete understanding and for the sole purpose of authorizing LTCG-HRT, at its discretion, to administer medication for the relief of body ailments, to enhance the physical condition and health of the Patient. The Patient consents to the receipt of any prescribed drug approved for medical use in the country of residence. The Patient understands that the methods of medical treatment offered or provided by LTCG-HRT or the Medical Providers are not accompanied by any claims, guarantees or promises.

3. **Compliance.** The Patient agrees to immediately cease any medical treatment prescribed by the Treating Physician in the event of any adverse response or side effect arising from prescribed treatment and provide immediate written notice to LTCG-HRT. The Patient further agrees to comply with instructions for use of any and all medications and to promptly contact a local physician for any necessary medical intervention should a complication or concern resulting from the use of a requested medication arise. The Patient acknowledges that there are risks as well as benefits to any medication, even over the counter drugs and have been fully informed of the possible effects, risks, and benefits of this medication.

4. **Assumption of Risk; Waiver of Claims.** The Patient understands and acknowledges that the practice of medicine is not an exact science and that diagnosis and treatment may involve risks of injury and acknowledges that no promises, assurances, or guarantees have been made as to the result of diagnostic testing, analysis of test results, and examination of medical history or treatment by LTCG-HRT or the Medical Providers. The Patient understands that the hormone blood level objective sought to result from hormone replacement therapy, as

Patient Initials: ____

prescribed by the Treating Physician, may be the highest level of a standard reference range for any sex and age, or may be an even higher hormone blood level than normally found in a person younger than the Patient. The Patient understands that hormone replacement therapy for the purpose of elevating hormone blood levels is experimental and may not render any benefits, but may result in unknown adverse results. The Patient is aware of the nature, risks, possible alternative methods of treatment, possible consequences, and possible complications involved in treatment. Accordingly, the Patient waives any and all claims against LTCG-HRT, its physicians, owners, members, managers, agents, and Medical Providers for the treatment provided by LTCG-HRT and its Medical Providers.

5. **Indemnification.** The Patient indemnifies and waives any and all claims or defenses that they may have against LTCG-HRT for any harm or injury suffered as a result of failure to fully disclose all relevant facts about the physical and medical condition of the Patient to LTCG-HRT or the Medical Providers, including, but not limited to, the information on the Medical History Form. The Patient also indemnifies LTCG-HRT and the Medical Provider for any and all claims and defense for injuries or illnesses sustained as a result of the failure to comply with the method of treatment and dosage schedule prescribed by the Treating Physician or any other Medical Provider.

ADDITIONAL TERMS AND CONDITIONS

6. **Expenses.** Except as otherwise expressly provided herein, all costs and expenses, including, without limitation, fees and disbursements of counsel, financial advisors and accountants, incurred in connection with this Agreement and the transactions contemplated hereby shall be paid by the party incurring such costs and expenses, whether or not the procedure shall have occurred.

7. **Headings.** The headings in this Agreement are for reference only and shall not affect the interpretation of this Agreement

Patient Initials: ____

Hormone Replacement Therapy

8. **Amendment and Modification; Waiver.** This Agreement may only be amended, modified or supplemented by an agreement in writing signed by each party hereto. No waiver by any party of any of the provisions hereof shall be effective unless explicitly set forth in writing and signed by the party so waiving. No waiver by any party shall operate or be construed as a waiver in respect of any failure, breach or default not expressly identified by such written waiver, whether of a similar or different character, and whether occurring before or after that waiver. No failure to exercise, or delay in exercising, any right, remedy, power or privilege arising from this Agreement shall operate or be construed as a waiver thereof; nor shall any single or partial exercise of any right, remedy, power or privilege hereunder preclude any other or further exercise thereof or the exercise of any other right, remedy, power or privilege.

9. **Governing Law; Jurisdiction.** This Agreement shall be governed by and construed in accordance with the internal laws of the State of Colorado without giving effect to any choice or conflict of law provision or rule (whether of the State of Colorado or any other jurisdiction). Patient expressly agrees that jurisdiction and venue for any medical, legal or equitable claim of any type whatsoever, or any dispute regarding pharmaceuticals, physicians, physician services, medical laboratories or any services or products provided to Patient by LTCG-HRT shall exclusively in the City and County of Denver, Colorado.

10. **Attorney Fees; Costs.** Patient agrees to pay all reasonable attorney's fees and court costs incurred by LTCG-HRT if such claim is brought in violation of the terms and conditions of this Agreement. Further, in the event LTCG-HRT prevails under any action brought under this Agreement by Patient or, alternatively, by LTCG-HRTagainst Patient, Patient shall pay all reasonable attorney's fees and costs incurred by LTCG-HRT in defending or prosecuting such claim. The parties hereto have caused this Testosterone Medication Use Agreement to be executed as of the date first written above by their respective officers thereunto duly authorized.

Patient Name _____

Patient Initials: ____

LoTurco Chiropractic PLLC

Hormone Replacement Therapy

Signature _____ Date _____/_____/___

LTCG-HRT**:** Signature: _____ Date _____/_____/___

Print Name: _____ Title:_____

Experience the benefits of added vitamins & supplements such as:

1. Improved Energy and Stamina
2. Reduced Stored Body Fat
3. Maintain Healthier Liver
4. Improved Sleep Quality and Duration
5. Increase Metabolism
6. Improved Mental Clarity
7. Balanced Immune System

FACTS ABOUT VITAMIN B12

1. Aging means we absorb less Vitamin B12 from food. It is estimated, 85% of us come up short of the necessary B12 from our diet.

2. Absorption of B12 in food requires a substance from our stomachs called intrinsic factor, the production of which decreases with age. The American College of Physicians assumes that no one has intrinsic factors past age 70. People with chronic fatigue or anemia require regular injections of Vitamin B12 because the oral form has unreliable side effects and warnings.

   a. Some redness and swelling at the injection site may occur, but it should begin to clear up within 48-hours

   b. Vitamin B12 is safe for most people; however, pregnant or lactating women should speak to their doctor prior to starting a B12 regimen

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c. Sensitivity to Cobalt and/or Vitamin B12 is a contraindication

d. Clients with chronic liver and/or kidney dysfunction, Leber's disease (Hereditary Eye Disease) or abnormal red blood cells (Megaloblastic Anemia) should not take frequent B12 injections.

FACTS ABOUT MIC

1. Methionine (M)- An amino acid; Acts to prevent excess fat build-up in the liver and the body. Helpful in relieving or preventing fatigue and may have action in the anti-inflammatory process by reducing histamine release.
2. Inositol (I)- A nutrient belonging to the B Vitamin Complex; Closely associated with choline. It aids in the metabolism of fats and it helps reduce blood cholesterol. Inositol participates in the action of Serotonin, a Neurotransmitter known to control mood and appetite.
3. Choline (C)- Supports liver health by processing and excreting chemical waste products in the body. In addition, it facilitates fat absorption by the cells. It is essential for the health of kidneys and liver.

- ❏ Add to monthly treatment package: $80.00
- ❏ Weekly intermittent treatment payment: $40.00
- ❏ Not interested at this time
- ❏ Yes, interested sponsored athlete/ representative of LTCG-HRT
- ❏ No, not interested sponsored athlete/ representative of LTCG-HRT

By signing below, I acknowledge that I have read the foregoing Informed Consent and I agree to treatment with its associated risks. I hereby give consent to perform this and all subsequent B12 and/or MIC+B12 Injections.

Patient Printed Name: _____ Date:

Patient Initials: ____

Hormone Replacement Therapy

Patient Printed Signature: _____ Date:

Appointment Cancellation & No Show Policy Agreement

LoTurco Chiropractic PLLC Hormone Replacement Therapy is committed to providing all of our patients with exceptional care. When a patient does not show for a scheduled appointment or cancels without giving sufficient notice to our care team, it prevents another patient from being seen.

Canceling or rescheduling an appointment requires a 24 hour notice, failure to call and adjust the scheduled appointment will result with a $25 fee assessed to the account it is listed under. **Please call (720) 476-5121**

I _____, understand and agree that if there is not provided a 24 hour notice, a $25 fee is assessed to the appointment account for a NO CALL, NO SHOW.

Patient Initials: ____