LOTURCO CHIROPRACTIC GROUP
Hormone Replacement Therapy Male Intake

Last Name:_____ First Name:_____ Initial: ____

DOB:_____-_____-_____

Address:_____

Apt:_____ City: _____ State: _____ Zip:_____

Phone: ( ) _____ - _____

Email:_____

Emergency Contact Name: _____ Phone:_____

We may contact you to provide appointment Reminders: (circle one) Yes No

How did you hear about us: _____

What is HRT ?

Hormone Replacement Therapy can serve a magnitude of needs, using a hormone that you already naturally produce but may be lacking, Testosterone. Our hormone levels decline with age which can cause several health problems, but HRT is designed to re-balance and replenish the hormones your body needs. HRT is a well-known treatment that helps with unnaturally low testosterone levels (testosterone deficiency), when other treatment options have failed. As a result this type of therapy can offer a plethora of benefits including increased energy, reduced fatigue, boost libido, and improve sex drive along with encouraging muscle growth and improve workouts.Rather than using transdermal pellets or topical creams our clinic uses injections, this way our clinicians can control your dosage with dynamic precision which is measured by doing continuous labs so that there is no guessing involved. Each and every patient has their own personalized plan for their HRT program ensuring that you are receiving the best care possible that works specifically for you!

Medical History

Primary Care Physician _____Phone:_____

List Prior hospitalizations, surgeries, (include year):

_____

List any medications you are currently taking and dosage

_____

_____

Do you have any allergies to medications? Yes No (circle one) If Yes, Please List:

_____

Do you use : Tobacco Alcohol IV drugs (circle all that apply)

Which of the following conditions have you or are currently being treated for (circle all that apply)

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

Please Describe any current/ past medical treatment not listed above:

_____

Male Urogenital History

(circle YES or NO)

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 your 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 Testical pain or swelling? YES NO

Date of last Colonoscopy? _____

Date of last Prostate and rectal Exam? _____

Male Symptoms of Low Testosterone

(circle all that apply)

Difficulty concentrating:	YES	NO
Moodiness:	YES	NO
Depression:	YES	NO
Cognitive issues:	YES	NO
Lower muscle mass and increased body fat:	YES	NO
Decreasing sex drive:	YES	NO
Increasing fatigue:	YES	NO
Decrease in Energy:	YES	NO
Daytime Sleepiness:	YES	NO
Poor sleep habits:	YES	NO
Erectile Dysfunction:	YES	NO

TESTOSTERONE MEDICATION USE AGREEMENT

I _____, hereby agree and authorize LCG-HRT to provide the patient diagnostic testing, medical care and prescribed pharmaceuticals based on the completed and accurate medical history from provided by patient , and any laboratory diagnostic tests obtained through LCG-HRT, pursuant to and subject to the terms and conditions of this agreement. I (the patient) understands that the Medical History forms become property of LCG-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. I am fully responsible for the cost and payment of these services.

Patient Signature _____ Date: _____

Pricing

HRT MALE monthly: $225

In order to give patients proper dosing

We require blood work initially, after the first 30 days, and every 90 days.

Initial Labs : $250

30 day labs: $200

90 day labs: $150

Therapeutic blood draw: $45

Prices may vary if you wish to add additional tests to labs

We also offer STI/D testing along with a multitude of other labs upon request.

Additional	Monthly Cost :	Cost Individually:	Benefits:
		W/O HRT:	Balanced Immune System
MIC+b12: (Weekly shot)	$80	$100	Increased Energy Boosted metabolism
Phentermine (Orally)	$80	$100	Appetite suppressant Burns Fat Energy Boost
NP Thyroid (Orally)	$80	$100	A natural preparation derived from porcine thyroid glands indicated to treat Hypothyroidism
Sermoralin (shot 5x per week)	$100	$125	Body fat reduction Increased endurance and strength Accelerated wound healing
BPC: (shot 5x per week) Anti-inflammatory.	$550 - Not offered at a bundle		Accelerated wound healing (muscle, ligament, tendon, nerve) Has been shown to decrease pain in damaged areas. Increases growth hormone receptors.

CONSENT FOR TREATMENT

I _____, Understand that in order for this treatment to be fully effective I must comply with the treatment plan as directed. If I do not comply as directed I understand that I will be discharged as a patient because it is a risk to my health.

INITIAL _____

I understand that in order to feel the full effects and results of this medication it will take anywhere from 30-90 days. **I understand that use and or abuse of alcohol and or drugs will make my treatment less effective.** INITIAL _____

I consent to have LoTurco Chiropractic Group & HRT and their employees evaluate and treat me. This includes but is not limited to collecting 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. INITIAL _____

I understand and acknowledge that the practice of medicine is not an exact science and that diagnosis and treatment may involve risks. 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 LCG-HRT.

INITIAL _____

I indemnify and waive any and all claims or defenses that I may have against LCG-HRT for any harm or injury suffered as a result of failure to fully disclose all relevant facts about my physical and medical conditions including but not limited to information on the medical history form. I will not hold LCG-HRT or its providers responsible 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.

INITIAL _____

If at any time I wish not to have these services rendered, I may state so. **I Understand that if I wish to stop this program it is in my best interest to let the providers know and they will help me safely stop by slowly reducing my dosage.**

Patient Signature _____ Date: _____

TESTOSTERONE MEDICATION USE AGREEMENT

I _____, hereby agree and authorize LCG-HRT to provide the patient diagnostic testing, medical care and prescribed pharmaceuticals based on the completed and accurate medical history from provided by patient , and nay laboratory diagnostic tests obtained through LCG-HRT, pursuant to and subject to the terms and conditions of this agreement. I (the patient) understands that the Medical History forms become property of LCG-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.

Patient Signature _____ Date: _____

Notice of Patient Rights and Privacy Practices

We are required by law to maintain the privacy of your health facts 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 any change, we will provide you with a written, revised notice upon request. These uses and disclosures require your written consent , and include but are not limited to the following information: Financial and medical records, Diseases spread person to person, such as Human Immunodeficiency Virus (HIV) & Acquired Immune Deficiency Syndrome (AIDS). Drug and or alcohol abuse, Psychiatric diagnosis treatment records, Laboratory Test results, Treatment progress.

We may release the above to :

Your insurance company, Medicare/ Medicaid, or any other person who will pay your bill for processing your bill for services in order for us to receive payment.

Any person from a program or 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 testing done or to which you may be admitted.

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, Ect:, Other health care people to start treatment.

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

1. In emergency treatment situations, we try to obtain consent as soon as possible after treatment. To avoid serious threats to health and safety.
2. Where significant barriers to communicating with you exist and we determine the consent is clearly inferred from the situation.
3. We are required by law to provide treatment and we are unable to obtain consent/the use or disclosure is required by law.
4. For certain public health activities, such as reporting births, deaths, injuries, or diseases.
5. If we strongly suspect you are a victim of abuse, neglect, or domestic violence or are a danger to yourself (we are required to report to local authorities/ government agencies authorized to to receive abuse/ neglect/ or domestic violence reports.)
6. Certain Law Enforcement purposes / Legal administrative proceedings.
7. If death were to occur we have permission to release information to coroners, medical examiners , funeral directors, organ/ tissue donations in certain situations (home health, hospice etc:)
8. For worker's compensation purposes.
9. The use of directory of people served by us. (clinic schedule)
10. To a family member or friend, or other person you choose who may assist in your care or payment for care. Other uses and disclosures will only be made with your written permission and may be withdrawn in writing at any time, except in limited circumstances.

We are allowed to use or disclose facts about you without your consent or authorization (provided you are informed in advance and given the chance to agree to or restrict or forbid) to disclose information for the stated above .
Patient Signature: _____ Date:_____

Patient Rights:<u>You have the right,</u> (subject to certain conditions)<u>, to:</u>

1. Request restrictions on certain facts about you via written request, 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.

I acknowledge that I have read and agree to the provider's notice of privacy practices with the effective: Date of _____ ___,_20____

Name of patient: _____ DOB: _____

Signature of patient/ representative: _____

(If not patient) Relationship to Patient: _____

CONSENT FOR DISCLOSURE

In general, The HIPAA privacy rule gives individuals the right to question a restriction on uses and disclosures of their protected health information (PHI).

The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternate means, such as sending correspondence to the individual's office instead of the individual's home.

Cancellation Policy

Loturco Chiropractic Group & HRT is committed to providing all of our patients with exceptional care. When a patient does not show for an appointment or is canceled without giving sufficient notice it prevents another patient from being seen.

I _____, Understand that canceling or rescheduling an appointment requires at least a 24 hour notice, failure to call/email will result in a **$40 fee.**

I understand that if I am **more than 5 minutes late** to a scheduled appointment I may have to wait for other patients ahead of me to be seen and or reschedule if the schedule is full.

Patient Signature: _____ Date _____