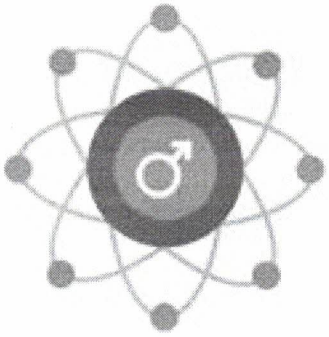


Low Testosterone & Wellness Center

Consent To Treatment

1. I _____ (patient name) give permission for **Low Testosterone and Wellness Center** to give me medical treatment.
2. I allow **Low Testosterone and Wellness Center** to file for insurance benefits to pay for the care I receive.
   I understand that:
   - **Low Testosterone and Wellness Center** will have to send my medical record information to my insurance company.
   - I must pay my share of the costs.
   - I must pay for the cost of these services if my insurance does not pay or I do not have insurance.
3. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my clinician.

Patient's Signature_____Date_____

Print Name_____

Low Testosterone
& Wellness Center

Consent to Have Blood Drawn for Testing

I hereby authorize the medical staff at Low Testosterone & Wellness Center to obtain a blood sample. I understand I may be responsible for separate lab charges from third party labs.

Signature_____ **Date**_____

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient 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 by contacting our office.

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 the agreement. By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment, and healthcare operations. 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 in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996(HIPPA). I agree that Low Testosterone & Wellness Center may request and use my prescription medication history form other healthcare providers or third-party pharmacy benefit payers for treatment purposes.

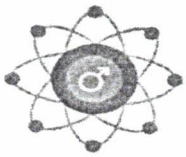
The patient understands that:

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

Signature of Patient: _____

Printed Name of Patient: _____

Date: _____



Low Testosterone & Wellness Center

Today's Date: _____ **SS#:** _____ **DOB:** _____

PATIENT INFORMATION:

Patient's Name: _____

I preferred to be addressed as: _____ Sex: __Male ___Female

Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

PRIMARY CARE/REFERRING PHYSICIAN INFORMATION:

Did a Physician Refer you? NO YES Name: _____

Who is your Primary Care Physician? _____

How did you hear about us? _____

DEMOGRAPHICS:

1. **Race:** American Indian/ Alaska Native Asian Black/African American White Native Hawaiian Other Pacific Islander More than One Race Refuse to Report
2. **Ethnicity:** Hispanic or Latino Not Hispanic Unknown
3. **Preferred Language:** English Spanish Creole Other: _____
4. **Preferred Notification Method:** Postal Mail Phone Email
5. **Marital Status:** Married Single Divorced Widow/Widower

EMERGENCY CONTACT INFORMATION

In case of an emergency, whom should we notify? _____

Relationship to Patient_____ Phone: _____

PATIENT EMPLOYMENT INFORMATION

Patient's Employer Name & Address_____

Employer's Phone: _____ Full Time Part Time Retired Unemployed

INSURANCE COVERAGE (we will need to make a copy of cards and ID for our records)

Primary Company Name: _____

Secondary Company Name: _____

Note: Except for exceptional cases we will only file with your **PRIMARY** carrier. This policy **excludes** patients with Medicare.

Low Testosterone
& Wellness Center

WELCOME TO THE LOW TESTOSTERONE & WELLNESS CENTER!

Through our desire to provide you with the most focused and personalized healthcare experience, we would like to understand the primary reason(s) that has brought you to see us today. Please take a few moments to identify which of the following you are hoping to achieve through your experience at the Low Testosterone & Wellness Center.

Primary Symptoms: Have you experienced any of the following symptoms? (check all that apply)

___Decreased Libido ___Decreased spontaneous erection ___Hot flashes ___Breast discomfort ___Gynecomastia

___Unusual sweating ___Loss of axillary or pubic hair ___Testes are less than 2.5cm in length

___Noticeable Decrease in testicular size

Secondary Symptoms: Have you experienced any of the following symptoms? (check all that apply)

___Weight Gain ___Fatigue ___Moodiness __Decreased Mental Clarity

Please assign a numerical value from 1-7 to each goal in order of importance

_____Management of a Chronic Illness

_____Weight Loss

_____Improved Energy

_____Physical Stamina & Endurance

_____Improved Sexual Functions

_____Increased Libido

_____Improved Quality of Life

Low Testosterone
& Wellness Center

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. Necessary forms will be completed, to file for insurance carrier payments.

Please Initial one to the following payment options:

Assignment of Benefits-Insurance

____I hereby assign all medical benefits, to include major medical benefits to which I am entitles. I hereby, authorize and direct my insurance carrier(s), private insurance and any other health/medical plan to issue payment check(s) directly to Low Testosterone & Wellness Center for medical services rendered to me and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Insurance Waiver and Payment Agreement-SELF-PAY

____I have chosen to be self-pay for health care services provided by Low Testosterone & Wellness Center. I have decided to be self-pay even though I may have health insurance that covers these services and waive my right to have a claim submitted to my insurance company on my behalf. I agree to pay for services in the office the date they are performed.

Authorization to Release Information

I hereby authorize Low Testosterone & Wellness Center: (1) release any information necessary to insurance carriers regarding my illness and treatments: (2) process insurance claims generated on the course of examination or treatment: and (3) allow a photocopy of my signature to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Low Testosterone & Wellness Center on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of my treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient/Responsible Party Signature Date

Low Testosterone
& Wellness Center

Consent for Testosterone Replacement Therapy

Patient Name: _____ DOB: _____

Therapeutic Objective. Testosterone Replacement Therapy is a therapy utilized in males to treat symptoms associated with the body's failure to produce adequate levels of testosterone. These symptoms may include reduced sexual desire or libido, decreased energy and motivation, changes in erectile frequency or quality, poor concentration or memory, feelings of irritability, mood disturbances, sleep disturbances, reduced muscle mass, increased body fat, changes in body hair, or gynecomastia (breast enlargement). The objective of the therapy is to reduce or eliminate these symptoms by returning the body's usable level of testosterone to a physiologic normal range.

Insurance Coverage. Testosterone Replacement Therapy (TRT) may be covered by health insurance, when the therapy is undertaken in relation to a new or established diagnosis of primary or secondary (or combined) hypogonadism, coupled with laboratory testing demonstrating low blood-serum levels of one or more of the following: Total Testosterone, free testosterone, or bioavailable testosterone (depending on the requirements of the insurance carrier). In some cases, you and your physician may decide that the treatment of TRT is medically necessary, even when your symptoms or blood test results do not meet the criteria of some insurance carrier. In that instance, your health insurance may not provide coverage for testosterone therapy, and you will be required to pay for the services at the time they are rendered. For patients who have access to an HSA or FSA, ordinarily you may choose to use these accounts to pay for treatment.

Risks and Contraindications. Any medical therapy involves risks, and you should discuss each of these with your health care provider. It is important to Low Testosterone & Wellness Center that you fully discuss whether therapy is right for you before commencing or continuing treatment. Normally, men who suffer from untreated obstructive sleep apnea, have a history of prostate or other cancer, or who are planning on having children should not participate in TRT. Side effects may include nausea, increased red blood cell count, acne, dry cough, breast enlargement, testicular atrophy, prostate enlargement, lowered sperm count, male pattern baldness, mood swings, injection sire reactions (bleeding, pain, swelling, redness, or infection), and fluid retention. Some studies have indicated a possible increased cardiovascular risk associated with testosterone use in certain patients. Patients using testosterone should seek medical attention immediately if symptoms of a heart attack or stroke are present, such as chest pains, shortness of breath or trouble breathing, weakness in one part or one side of the body, or slurred speech. Each patient's own risks may vary depending on medical history and lifestyle. It is important that you provide an accurate and complete medical history to your provider. If you have history of cardiac, urologic, or other medical problems, your provider may require clearance from your cardiologist, urologist, or other treating physician. Please tell your provider if you have used alcohol, illegal drugs, or other steroids prior to your treatment visit.

Low Testosterone
& Wellness Center

Patient:

This is my consent for any physician, provider or nurse who works with the Low Testosterone & Wellness Center, to initiate and/or continue treatment.

_____I have read and understand this consent form and have had the opportunity to discuss my complete past medical and health history including serious problems and/or injuries, as well as family history of diseases and conditions with my health care provider. All of my questions concerning the risks, benefits, and alternatives to treatment have been answered. I desire to initiate and/or continue treatment. I understand that each patient is different and there are no guarantees as to results obtainable from treatment. Treatment is not a cure, and if I stop treatment, symptoms may return or worsen.

__I understand that I will have periodic blood and urine tests as recommended by my providers, and I consent to such testing.

__Prices for treatment have been fully explained to me and if my insurance does not cover treatment, I will be charged the current price for treatment and any associated laboratory testing. I agree to pay for those services at the time they are rendered.

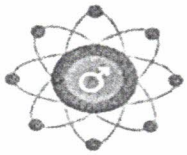
_____ _____

Patient Signature Date

I have reviewed each of the foregoing with the patient, including discussing the potential risks and benefits of treatment, the patient's complete medical, health history and relevant family medial history. The patient has been provided the opportunity to ask questions concerning the risks, benefits and alternatives to treatment, and desires to: (circle one) Commence/Refuse or discontinue treatment.

_____ _____

Provider's Signature Date



Low Testosterone
& Wellness Center

Authorization for Release of Protected Health Information

Patient Name: _____ DOB: _____

INITIAL ONE:

__I hereby authorize all medical services sources and health care providers to use and/or disclose the protected health information (PHI) described below to:_____ via Fax_____ **OR**

_____I hereby authorize my healthcare providers at Low Testosterone & Wellness Center to release and/or disclose the protected health information (PHI) describer below to:

Name: _____ Relationship_____

Purpose of Release: _____

Pick-up by: _____

Fax: _____

Other: _____

Email (not recommended): _____

-Authorization for release of PHI covering **(check one)**

__Last Labs Only

__All records from(date)_____to(date)_____

__All past, present, and future records.

-I hereby authorize the release of the above PHI as follows **(check one):**

__my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse):

OR

__my complete health record with the exception of the following information (check all that apply):

__Mental Health

__Communicable diseases (including HIV and AIDS)

__Alcohol/drug abuse treatment

__Other (please specify) _____

This authorization is valid until revoked by me in writing.

_____ _____

Patient Signature Date

OFFICE FOR CIVIL RIGHTS

YOUR HEALTH INFORMATION PRIVACY RIGHTS

Most of us feel that our health information is private and should be protected. That is why there is a federal law that sets rules for health care providers and health insurance companies about who can look at and receive our health information. This law, called the Health Insurance Portability and Accountability Act of 1996 (HIPAA), gives you rights over your health information, including the right to get a copy of your information, make sure it is correct, and know who has seen it.

Get It.

You can ask to see or get a copy of your medical record and other health information. If you want a copy, you may have to put your request in writing and pay for the cost of copying and mailing. In most cases, your copies must be given to you within 30 days.

Check It.

You can ask to change any wrong information in your file or add information to your file if you think something is missing or incomplete. For example, if you and your hospital agree that your file has the wrong result for a test, the hospital must change it. Even if the hospital believes the test result is correct, you still have the right to have your disagreement noted in your file. In most cases, the file should be updated within 60 days.

Know Who Has Seen It.

By law, your health information can be used and shared for specific reasons not directly related to your care, like making sure doctors give good care, making sure nursing homes are clean and safe, reporting when the flu is in your area, or reporting as required by state or federal law. In many of these cases, you can find out who has seen your health information. You can:

- **Learn how your health information is used and shared by your doctor or health insurer.** Generally, your health information cannot be used for purposes not directly related to your care without your permission. For example, your doctor cannot give it to your employer, or share it for things like marketing and advertising, without your written authorization. You probably received a notice telling you how your health information may be used on your first visit to a new health care provider or when you got new health insurance, but you can ask for another copy anytime.
- **Let your providers or health insurance companies know if there is information you do not want to share.** You can ask that your health information not be shared with certain people, groups, or companies. If you go to a clinic, for example, you can ask the doctor not to share your medical records with other doctors or nurses at the clinic. You can ask for other kinds of restrictions, but they do not always have to agree to do what you ask, particularly if it could affect your care. Finally, you can also ask your health care provider or pharmacy not to tell your health insurance company about care you receive or drugs you take, if you pay for the care or drugs in full and the provider or pharmacy does not need to get paid by your insurance company.

- **Ask to be reached somewhere other than home.** You can make reasonable requests to be contacted at different places or in a different way. For example, you can ask to have a nurse call you at your office instead of your home or to send mail to you in an envelope instead of on a postcard.

If you think your rights are being denied or your health information is not being protected, you have the right to file a complaint with your provider, health insurer, or the U.S. Department of Health and Human Services.

To learn more, visit **www.hhs.gov/ocr/privacy/**.

For more information, visit **www.hhs.gov/ocr**.

U.S. Department of Health & Human Services
Office for Civil Rights

PLEASE PLACE A CHECK OFF IN RELATION TO YOUR HISTORY AND SYMPTOMS

Chief concerns/Reason for visit:

__Fatigue __Decreased libido __Erectile Dysfunction __Decreased muscle mass __Weight concerns __Mood concerns

Clinical Comments:

_____

_____

Symptoms began _____months/years ago

Severity of Symptoms: Mild Mild to Moderate Moderate Severe

Modifying Factors: _____ Timing of Symptoms_____

Have you experienced any of the following?

Metabolic:

__Increased blood pressure ____Increased blood sugar Additional Comments_____

Musculoskeletal:

__Decreased in muscle size, tone, strength __Decrease in physical capabilities/performance Additional Comments_____

Mental Function:

__Fatigue, especially in the afternoon __Decreased in mental sharpness Additional Comments_____

Sexual Function

__Decreased morning erections __Decreased libido __Erectile Dysfunction Additional Information_____

Sleep Disorder

History of Sleep Apnea __Yes __No Additional Info. _____

Annual Exam

Comprehensive physical exam in the last 12 months? ___Yes ___No

Prostate Exam

Prostate Exam/Evaluation in the last 12 months? ____Yes ____No

PMFSH

Drug Allergies: _____

Current Medications_____

History of Cardiac Disorder Event:

__Heart Attack Date: _____

__ Stroke Date: _____ Type: _____

__ Blood Clot, DVT, Pulmonary Embolism Date: _____ Type: _____

__Coronary artery bypass graft surgery (CABG):

Date: _____

__Aortic valve disorder Date: _____ Type: _____

__Mitral valve disorder Date: _____ Type: _____

__Endocarditis Date: _____ Type: _____

__Pericarditis Date: _____ Type: _____

__Cardiomyopathy Date: _____ Type: _____

__Cardiac conduction disorder (AV block, Bundle branch block, Mobitz type all AV)

Date: _____ Type: _____

__Cardiac Arrhythmia (Atrial fibrillation/flutter, Paroxysmal supraventricular tachycardia, etc.)

Date: _____ Type: _____

__Heart failure (Congestive heart failure, etc.) Date: _____ Type: _____

Past Medical History (Hx)

__Prior testosterone replacement/exposure __Sleep Apnea __Snoring __Chronic kidney disease __Abnormal liver function
__Heart disease __High blood pressure __High Cholesterol __Peripheral artery disease __AIDS __Mumps __HIV
__Inability to father children despite unprotected sexual relations for more than 1 year __Chronic Lymph node enlargement __Diabetes
__Hypothyroidism __Enlarged Thyroid __Enlarged Prostate __Hx Prostate Cancer __Hypogonadism __Anxiety
__Depression __Acid Reflux __Anemia __Hemochromatosis __Blood disorder __Obesity
__Cottonseed Allergy __History of Seizures
Other:_____

Past Surgical History

__Vasectomy: _____ Other Surgeries: _____

Other Urinary Surgery: _____

Family History (Hx)

__Prostate Cancer: Who? _____

__Cardiovascular Disease: _____

__Breast Cancer: _____ ____Heart Attack __Stroke __Diabetes __Hypothyroidism __Delayed Puberty ___Reproductive Disorder
__Endocrine disease_____

Social History

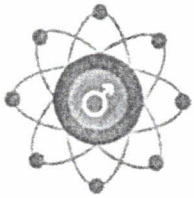
__Smoker_____ __Smokeless tobacco use_____

__Chronic opioid/pain medication use_____ __ Alcohol use:_____ __ Recreational drug use_____

__Exercise _____ ___Caffeine_____

Marital Status: Married Single Divorced Widowed

Children: None Biological Adopted Step Children Number of Children: _____ Do you desire more children? Yes No



Low Testosterone & Wellness Center

ROS (circle all that apply)

Constitutional: Abnormal weight gain Abnormal weight loss Night Sweats

Ear/Nose/Throat: Hearing loss Tinnitus Altered sense of smell

Eyes: Blurry vision Double vision Visual disturbances

Chest: Nipple tenderness Breast enlargement

Respiratory: Persistent nonproductive cough Wheezing Shortness of breath

Cardiovascular: Chest pain/pressure Palpitations Pain in the lower legs with walking Fainting spells

Dizziness

Gastrointestinal: Heartburn Abdominal pain Persistent nausea Vomiting

Genitourinary: Urinary frequency Frequent night urination Urinary urgency Urinary hesitancy

Dribbling after urination Pain with urination Blood in urine

Erectile dysfunction Decreased libido

Neurological: Frequent headaches rm and/or leg weakness Difficulty with speech Chronic pain

Musculoskeletal: Joint pain Muscle pain Muscle weakness

Integumentary: Suspicious skin lesions Recurrent rashes Acne

Psychiatric: Depressed mood Anxiety Irritability Insomnia Low Self-confidence

Endocrine: Hot/Cold intolerance Appetite changes Excessive thirst

Immune/Allergy: Hives

International Prostate Symptom Score (I-PSS)

Patient Name: _____ Date of birth: _____ Date completed _____

In the past month:	Not at All	Less than 1 in 5 Times	Less than Half the Time	About Half the Time	More than Half the Time	Almost Always	Your score
1. Incomplete Emptying How often have you had the sensation of not emptying your bladder?	0	1	2	3	4	5	
2. Frequency How often have you had to urinate less than every two hours?	0	1	2	3	4	5	
3. Intermittency How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
4. Urgency How often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Weak Stream How often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Straining How often have you had to strain to start urination?	0	1	2	3	4	5	
	None	**1 Time**	**2 Times**	**3 Times**	**4 Times**	**5 Times**	
7. Nocturia How many times did you typically get up at night to urinate?	0	1	2	3	4	5	
Total I-PSS Score							

Score: 1-7: *Mild* 8-19: *Moderate* 20-35: *Severe*

Quality of Life Due to Urinary Symptoms	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	**0**	**1**	**2**	**3**	**4**	**5**	**6**