NorCal HRT

Bio Identical Hormone Replacement and Wellness

DEMOGRAPHIC INFORMATION **VISIT DATE**__________________

Last Name________________________________ First Name_______________________________ M. I. _______

Date of Birth _________________Age _______ Gender: Male / Female *Gender Id (optional): L / G / B / T / Q*

Primary Phone (c / w / h) ______________________ Secondary Phone (c / w / h) _______________________

Mailing Address ___________________________________ City _____________________ Zip Code____________

Email____________________________________ Emergency Name & Number_____________________________

Employer Name _______________________________ Patient Occupation _________________________________

How did you hear about us? ☐ Referral by ___________________ ☐ Website/Internet/Other____________

Primary Care Physician: _____________ Referring Physician: _____________ Marital Status: ________________

Please describe present issue:

How & when did the symptom(s) begin?

REVIEW OF CURRENT SYMPTOMS

Irregular Periods	Painful Sex	Nighttime Urination	Difficulty Swallowing
PMS	Vaginal Dryness	Urinary Flow Issues	Fatigue
Mood Swings	Erectile Dysfunction	Dry Skin	Brain Fog
Weight Gain	Low Muscle Mass	Thinning Hair	Depression
Bloating/Water Retention	Diarrhea	Acne	Anxiety
Sexual Dysfunction	Constipation	Irregular Facial Hair	Hair Loss
Low Sex Drive	Burning Urination	Hot Flashes	
	Vaginal Discharge	Difficulty Sleeping	

LIFESTYLE

Tobacco use? Yes / No; If "yes," what type? ________________________Frequency? ________________

Alcoholic beverages (# per day) _______________ caffeinated bev or supplements (# per day) __________

CURRENT MEDICATIONS/ SUPPLEMENTS

____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________

Drug Allergies: ____

PAST MEDICAL HISTORY

None	Blood Clots	Osteoporosis	Prostate Enlargement (BPH)
Heart Disease	Bleeding Disorders	Allergy: Food	Fibroids
High Blood Pressure	Hepatitis A B or C	Allergy: Seasonal	Prostatitis
Stroke/TIA	HIV	Hypothyroid	**Other Medical Conditions (list):**
Obstructive Sleep Apnea	Diabetes- Diet Controlled	Hyperthyroid	
Coronary Artery Disease	Irritable Bowel Syndrome	Endometriosis	
Depression	Neuropathy	PCOS	
Anxiety	High Cholesterol	Infertility	
		Brain Injury	

SCREENING TESTS:

Colonoscopy YEAR: ________ Mammogram YEAR: ________ Pap smear YEAR: ________ DEXA scan:_______

SURGERIES/ HOSPITALIZATIONS AND OR PROCEDURES

____________________YEAR________ ____________________YEAR________ ____________________YEAR________

FAMILY MEDICAL HISTORY

Heart Disease
Diabetes

Clotting Disorders
Cancers/Type & Whom:

Other: ____

Mother: Age ________ Living / Deceased; If deceased, died of ________________________________
Father: Age ________ Living / Deceased; If deceased, died of ________________________________

Informed Consent

I the undersigned patient, understand and acknowledge that the practice of medicine is not an exact science and that all diagnosis and treatment may involve risks or injury. I acknowledge the no promises, assurances or guarantees have been made to me as to the result of diagnostic testing, analysis of the test results, examination of medical history, or treatment provided to me by Blake Massey PA-C at NorCal HRT. Blake Massey PA-C is under the direct supervision of Dr. Paul Davis D.O.

I understand that the objective of bio-identical hormone replacement therapy, as prescribed by Blake Massey, is to achieve the highest level in the standard reference range for my sex and age, or an even higher hormone level than is generally found in a person of similar demographics. I understand that hormone replacement therapy may not render any benefits and that it may result in unknown adverse results.

I understand that i am participating in a program designed to treat the symptoms of low hormones and have been made aware that the FDA does not recognize nor support use of Bio-identical hormones.

A subset of BIHRT is the treatment of sub clinical hypothyroidism. This includes treating the symptoms of low thyroid function. In many cases, the actual thyroid gland is functioning properly. We may use off label thyroid medication(s) to treat the symptoms of low bio available cellular free T3 and free T4 levels.

I am participating in bio-identical hormone replacement therapy of my own free will, at my expense and my own liability. I assume all responsibility for the use of bio-identical hormone replacement. I understand that it is my responsibility to have a primary care provider to perform a annual physical examination, males DRE, annual gynecological exam/breast exam/mammogram ,if indicated and in some cases thermography. This may also include laboratory tests to ensure that I have no diseases or conditions which might make Bio-identical hormone replacement inappropriate. I also understand that this therapy requires continuous laboratory monitoring as recommended and ordered by Blake Massey PA-C.

I have been made aware of and instructed as to the potential complications and risks associated with the use of Bio-identical hormones to include: Cardiovascular events like MI, stroke and blood clotting events as well as possible cancers such as Breast, Ovarian and Prostate.

I have been made aware of the possible complications and risks involved in my treatment and I execute this form for the purpose of authorizing Blake Massey PA-C/ NorCal HRT for treatment and care.

I agree to answer all queries and to be candid in revealing all medical conditions and symptoms on medical forms, symptoms questionnaires or verbal consultations.

I understand that no medical provider or program can be the sole treatment and that life style modification, proper nutrition and healthy lifestyle are essential to a successful outcome.

I release NorCal HRT and all of its employees and contractors, including medical providers, from any and all seen or unforeseen liability associated or connected with the use of Bio-identical hormone therapy and all other treatments received at NorCal HRT.

Print Name | Date of Birth

Signature | Date

WHY WE DO NOT ACCEPT INSURANCE

Many people who have contacted out office for our services have asked us why we do not bill insurance directly, while other medical providers do. We fully understand the financial challenge this presents to some patients and we wish there were a way for us to bill your insurance company. Unfortunately, there is not a way for us to bill insurance and here is why:

When clinics bill health insurance companies directly, the physicians are required to become participating providers. The physician must sign a contract that allows the insurance company to determine which services they will and will not provide. And how much they can charge for those services. In general, insurance companies are not focused on any preventative or wellness services. They are heavily invested in the conventional model of health care that too often relies on drugs and surgery. We are committed, using Bio-Identical Hormone Replacement Therapy (HRT), to the preventative wellness model that addresses the underlying causes of your symptoms.

NorCal HRT does NOT accept **MEDICARE** or any other insurance providers. Please do NOT submit any reimbursement forms or receipts for services rendered to these entities.

By signing below, I acknowledge that I have read and understand all the above described regarding insurance and seeking reimbursement and will NOT further contact NorCal HRT regarding insurance billing.

Print Name

Signature

Date

CONFIDENTIALITY NOTE

Federal and State policies mandate that your healthcare information may not be disclosed to anyone without your permission. This policy includes a spouse, child or other relative, or anyone who might inquire as to your health and/or account information. Appointment confirmations by telephone are normally performed the day prior to a scheduled appointment. We require your permission to leave a brief telephone message on an answering machine or voicemail, or to a family member or to anyone answering your telephone.

I, ____, give permission that messages regarding appointments may be left on my home answering machine/voicemail or given to the person answering the telephone.

Please list the names of relatives or friends who may inquire as to my health, appointments or account status. If a spouse is not listed, we will assume information should not be released, I hereby authorize you to release information to the following people:

Name Relationship

Name Relationship

Name Relationship

Name Relationship

This authorization is for family members and friends only. It is my understanding that information must be released to my insurance carrier(s), or to auxiliary medical services such as hospitals, laboratories, pharmacies, billing services, business associates, etc. in order to process my health care data.

Signature Date

ALTERNATIVE OPTION:

It is my wish that information regarding my health, appointments, and account states NOT be released to anyone other than me.

Signature Date

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.
Article 2: ALL CLAIMS MUST BE ARBITRATED: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term 'patient' herein shall mean both the mother and the mothers expected child or children. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership and the employees, agents and estates of any of them, must be arbitrated, including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect the assertion of any claim, against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.
Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit
Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.
The parties consent to the intervention and joinder in the arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.
The parties agree that provision of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure.
Article 4; General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitration shall be governed *by* the California Code of Civil Procedure provisions relating to arbitration.
Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days of signature and if not revoked will govern all medical services to the physician within 30 days of signature and if not revoked will govern all medical services received by the patient.
Article 6: Retroactive Effect: If the patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below.
Effective as of the date of first medical services.

Patient's or Patient's Representative's Signature

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.
I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: BLAKE MASSEY, PA-C / Paul Davis D.O. - **NorCal HRT**, 760 Cypress Ave. Ste. 303, Redding, CA 96001 - 530-921-3601

Patient's Signature   Date

Print Name

Patient's Representative's Signature   Date

Print Name   Relationship to Patient

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

Office Policies

PLEASE READ CAREFULLY

Email Communication , Text and Telemedicine

I understand that NorCal HRT has a secure encrypted email server for incoming emails and cannot assure the security of outgoing emails. I may email NorCal HRT with any quick updates or concise questions. I understand that the email system is for NON emergency issues and can expect an reply within 72 hours. I consent to receiving emails , text reminders for appointments and participating in Telemedicine visits.

Primary Care Provider

I understand that NorCal HRT patients MUST obtain a primary care provider for whom is aware and agreeable with the NorCal HRT medical treatment plan. Sharing of information, including the medications I take is essential for compliance as well as safety.

48-hour policy

I understand that in order to be a participant in the NorCal HRT program, a **48-hour notice minimum is required to cancel or reschedule**.

If I "No-Show" or cancel my appointment within 48-hours of the scheduled appointment date and time, ***a $50 fee*** may be charged to my account. I understand that NorCal HRT has very limited appointment times available per week and must adhere to this 48-Hour scheduling policy for business purposes.

By signing below, I UNDERSTAND ALL THAT IS DETAILED ABOVE REGARDING EMAIL COMMUNICATION, PRIMARY CARE PHYSICIANS AND WILL PAY ANY FEES, IF INCURRED;

____

Print Name

____

Signature Date

CONTROLLED SUBSTANCE AGREEMENT

For schedule III and IV controlled medications to include Testosterone, Ambien, Lunesta & Benodiazepines

Patients on controlled schedule III or IV medications MUST be seen for a FOLLOW UP appointment every 4 months to comply with STATE and FEDERAL GUIDELINES.

I understand that I may be prescribed controlled medications and that these may have an abuse potential.

I will only obtain these controlled medications from one provider and one pharmacy. I will advise my medical provider if any other controlled medication has been prescribed to me from another medical provider.

I have been advised that a Cures report will be obtained every 4 months as federal and state guidelines require as well as having an appointment 4 months to obtain a new prescription for these controlled medications.

I will not take any illegal products to include anabolic steroids not prescribed by NorCal Hrt. I understand that if I do, I may be discharged from the practice; as these may be harmful and detrimental to one's wellbeing and health.

I understand that if any deviations from this agreement that I may be grounds for discharge from the medical practice.

By signing I understand and agree to the terms described above.

Print Name

Signature Date