ALLEGHENY MEDICAL
HORMONE THERAPY

HORMONE THERAPY PATIENT INTAKE FORM

Appt DATE:_____
TIME:_____ ACCT#_____
Provider: Kelley DeFilippis, CRNP

LAST Name:_____ FIRST Name:_____ Middle Initial:_____

Home address:_____ City:_____ State_____ Zip code:_____

Mobile #_____ Birth date: ____/____/_____ Gender:____ □ Single □ Married □ Other

Emergency Contact Name:_____ Reletionship:_____ PHONE#_____

Other than yourself who do you designate to disclose protected health information to:

What is the best way to communicate to you between office visits if necessary? (Choose as many)

□ Text (# as above) □ Mobile phone call □ Email How were you referred:_____

Pharmacy name:_____ Phone#_____

Occupation:_____ Employer:_____

FAMILY HISTORY - When, what age and/or age of death

FATHER: □ Stroke_____ □ Heart Disease_____ □ Blood Clot(s)_____

□ Osteoporsis_____□ Cancer_____ OTHER_____

MOTHER: □ Stroke_____ □ Heart Disease_____ □ Blood Clot(s)_____

□ Osteoporsis_____□ Cancer_____ OTHER_____

SIBLING □ Brother □ Sister

□ Stroke_____ □ Heart Disease_____ □ Blood Clot(s)_____

□ Osteoporsis_____□ Cancer_____ OTHER_____

SIBLING □ Brother □ Sister

□ Stroke_____ □ Heart Disease_____ □ Blood Clot(s)_____

□ Osteoporsis_____□ Cancer_____ OTHER_____

LABS/ECT: Date of last labs:_____ Please provide copies or □ On file w/ AM

Provide last provider seen and when:_____

List current medications and/or supplements:_____

_____

_____

_____

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MALE PERSONAL MEDICAL HISTORY

1. Do you have any medical &/or genetic history, please explain:_____

   _____

2. Have you been treated for cancer □ no □ yes, if yes, please explain, when/type of trmt/ with what provider and/or hospital, etc:_____

   _____

   _____

   Please provide pathology /oncology reports

3. Last Colonoscopy_____

4. Decreased in libio □ no □ yes, if yes, please explain:_____

5. Erectile dysfuntion □ no □ yes, if yes, please explain:_____

6. Hair Loss □ no □ yes □ pubic □ underarm □ body □ beard loss OTHER:_____

   _____

7. Are you unable to build muscle □ no □ yes

8. Fatigue □ no □ yes

9. Weight gain □ no □ yes

10. Shrinking testicle □ no □ yes

11. Depression □ no □ yes

12. Gynecomastia (enlarged breast tissue) □ no □ yes

13. Hot flashes □ no □ yes

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The patient or legal guardian must sign authorizations, such as in the case of a minor or when a patient is physically or mentally incompetent to sign. If patient is able to sign by marking an X, legal guardian must witness signature.

CONSENT FOR TREATMENT:

The information I have provided is complete and true to the best of my knowledge. I authorize the doctors and staff of Allegheny Medical, P.C. to administer procedures and treatment as deemed necessary, or as required.
There is no written, verbal, or implied guaranteed cure on our part. Due to our commitment to quality healthcare, we strive to improve services to our patients and we ask your consent prior to rendering treatment or services.

Name of Patient: _____

Signature of Patient: _____ Date: _____

Signature of Guardian: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY: PRACTICES FOR PROTECTED HEALTH INFORMATION:

I acknowledge that I have received and read "Notice of Privacy Practices" from Allegheny Medical, P.C.

Name of Patient: _____

Signature of Patient: _____ Date: _____

Signature of Guardian: _____ Date: _____

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CONTROLLED SUBSTANCE/NARCOTIC PRESCRIPTION POLICY

Allegheny Medical's controlled substance/narcotic policy for all patients is detailed below:

- Each prescription will be written for a 30-day supply, with no refills.
- Patients will need to be seen every 90 days by the provider prescribing the medication, or more frequently as determined by the provider.
    - Patient subject, but not limited to, routine bloodwork, EKGs, and other screening measures as determined by ordering provider. The provider has the right to modify, change, or deny medication and dosage based on any findings or contraindications.
- Narcotic prescriptions (controlled substances) are all electronically prescribed and sent to the pharmacy. No written prescriptions are permitted.
- Patients need to use the same pharmacy all the time, advance notification of pharmacy changes must be given to office, once the controlled substance is electronically prescribed.
    - Out of state prescriptions will not be filled, unless prior communication and approval by the ordering provider is obtained.
- A prescription will not be re-prescribed to a different pharmacy.
    - The only exception will be if the pharmacy is out of stock of the medication. It is the patient's responsibility to contact the alternate pharmacy to ensure the medication and the prescribed strength are available. Should the original and alternate pharmacy not be able to fill, the controlled substance will not be prescribed any further.
- If we find that the patient is obtaining narcotics from another provider, we will terminate our relationship immediately unless the medication is related to a post-surgical procedure.
- Patients are responsible for the controlled substance prescription given to them. If prescriptions are misplaced, stolen, lost, or if the medication "runs out early," the medication will not be replaced under any circumstance.
- Patient is subject to voluntary evaluations by psychologists and/or psychiatrists, possibly at their own expense, before any substance will be prescribed. I agree that the need to be evaluated by psychologists and/or psychiatrists may be revisited every 3 to 6 months thereafter while taking the medication.
- Patients will be subject to random urine drug screening to verify that the medications are being taken as prescribed. This will be at the provider's request. Urine drug screens cannot be billed to insurance and will be charged to the patient.

Please be aware that all medication management is at the providers discretion and not guaranteed. Failure to comply will result in discontinuation of the medication, referral to an outside provider for further management, and possible discharge from the practice. Thank you for your cooperation on this matter.

I have read and understand my responsibilities as outlined above. I acknowledge the receipt of the notice of the narcotic policy.

Patient Signature: _____ DOB: _____

Print Name: _____ Date: _____

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MISSED APPOINTMENT AND CANCELLATION POLICY

Our goal is to provide quality individualized care in a timely manner to each patient. No-shows, late arrivals, and cancellations inconvenience those individuals who need access to care.
Please review our policy regarding missed appointments.

CANCELLATION OF AN APPOINTMENT

Appointments are in high demand. If you need to reschedule an appointment for any reason, we **require 48-hour notice**. This policy enables us to better utilize available appointments for patients in need of care. A cancellation is considered late when the appointment is cancelled without 48-hour advance notice.

MISSED APPOINTMENTS (NO SHOWS)

You will be charged a $75 missed appointment fee if we do not receive a 48-hour notice of cancellation.

If you miss an appointment with Kelley DeFilippis and did not cancel or reschedule, it becomes a "NO SHOW" you will be charged a $100 missed appointment fee.

If a second appointment is missed, you will be charged the cost of services that would have been incurred at the time of the appointment.

If a third appointment is missed within a year, and no appointment is rescheduled, you will be dismissed from care with the practice.

LATE ARRIVALS

Patients arriving 15 minutes or later for an appointment will be asked the following:

1. If your appt is a 15 min appt time slot you will be ask to reschedule
2. If you appt is a 30 or 45 min appt time slot, your appt w/provider will be deducted by time late.
   (example you have a 45 appt your 15 mins late your appt will now be 30 min appt)

I have read and understand the Missed Appointment, No Show, late Arrival, and Cancellation Policy of Allegheny Medical and I agree to its terms.

Name of Patient: _____

Signature of Patient: _____ Date: _____

Signature of Guardian: _____ Date: _____