Innovative
HEALTH AND WELLNESS

**PATIENT INFORMATION FORM**

Name:_____ Date of Birth:_____
First Middle Last

Address: _____
Street City State Zip

Phone Number: _____ Email: _____

Soc Sec#:_____ Marital Status: SINGLE MARRIED DIVORCED WIDOWED SEPERATED

What is your preferred method of communication? Phone ☐ Email ☐ Mail ☐

Patient's Employer:_____ Work #: _____

Emergency Contact: _____ Phone Number: _____

Do you have medical insurance? ☐ Yes ☐ No

Insurance Company: _____ Policy Number:_____

Group Number:_____ Policy Holder's Name:_____

Policy Holder's Date of Birth: _____ Relationship: _____

Who may we thank for referring you: _____

**RESPONSIBLE PARTY**

Name Responsible for Account: _____

Relationship to Patient: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Email: _____

***Patient Signature:***_____ ***Date:***_____

# Health History Questionnaire

## Hormone Replacement Therapy

Patient Name: _____ DOB: _____ Date: _____

Have you been a patient before in another office? Yes □ No □

Do you have any preconceived ideas / thoughts / opinions? Yes □ No □

What "symptom" is most important to get resolved?

Tiredness □ Libido □ Concentration □ Poor Sleep □ Loss of muscle mass □ Belly fat □ Motivation □ Vigor for life □

**If we could wave a "magic wand" and grant you exactly what you would like out of this program, what would it be? Try to be as honest and specific as possible.**

Please list at least 3 different things

1. _____
2. _____
3. _____

### SYMPTOMS OF LOW TESTOSTERONE LEVEL

Decreased concentration ____ Yes ____No

Difficulty learning new things ____ Yes ____No

Memory loss ____ Yes ____No

Moodiness ____ Yes ____ No

Depression ____ Yes ____No

Increasing fatigue ____ Yes ____No

Decreasing energy ____ Yes ____No

Daytime sleepiness ____ Yes ____ No

Poor sleep habits ____ Yes ____No

Erectile dysfunction ____ Yes ____ No

I have had testosterone checked previously _____ Yes ____ No

I have used testosterone previously ____ Yes ____ No

If yes, date(s): _____ Type: _____ Usage: _____

If yes, date(s): _____ Type: _____ Usage: _____

Do you have any idea how hormone replacement therapy works? ____ Yes ____ No

Signature: _____ Date: _____

# Health History Questionnaire

Patient Name: _____ DOB: _____ Date: _____
Primary Care Doctor (PCP): _____ Phone number: _____
Pharmacy Number: _____ Date of last physical exam: _____

**PERSONAL HEALTH HISTORY**

**Please circle all that apply:**

**General Health:** Diabetes, high cholesterol, family history of cancer personal history of cancer, weight loss
**Cardiovascular**: Chest pain, heart failure, heart murmur, vascular disease, blood clots, fainting, lower extremity edema, hypertension (High blood pressure)
**Respiratory:** Sleep apnea, shortness of breath, asthma, bronchitis, pneumonia, allergies, hay ever
**Gastrointestinal**: Lactose intolerance, gallbladder, gall stones, diarrhea, constipation
**Genitourinary:** Prostate cancer- personal or family, overactive bladder/frequent urination, painful urination Decreased force of urination, on/off urine flow, incomplete emptying of bladder, prostate Enlargement/BPH, burning during urination, blood in urine, history of kidney or bladder Infection, kidney or bladder infection in the last 12 months, liver disease
**Psychiatric**: History of depression

**List your prescribed drugs and any over-the-counter drugs, such as vitamins and inhalers:**

Drug Name _____ Dosage _____ Frequency _____ Taken for _____
Drug Name _____ Dosage _____ Frequency _____ Taken for _____
Drug Name _____ Dosage _____ Frequency _____ Taken for _____
Drug Name _____ Dosage _____ Frequency _____ Taken for _____
Drug Name _____ Dosage _____ Frequency _____ Taken for _____

**Allergies:** _____ No Known Allergies
Or List Allergies and Reaction _____
_____

**Surgeries:**

Year _____ Surgery/Reason _____
Year _____ Surgery/Reason _____

**HEALTH HABITS AND PERSONAL SAFETY**

Alcohol: Yes ____ No ____ Number of drinks per week : _____
Tobacco : Yes ____ No ____ Cigarettes ____ Cigars ____ Chewing ___ How many/much : _____
Illicit drug use : Yes ____ No ____

**Exercise:** _____ Sedentary (No exercise) _____ Mild exercise _____ Occasional vigorous exercise _____ Regular vigorous exercise
**Describe type of exercise and frequency (resistance training, cardiovascular, number of times per week, etc.):**
_____
_____

Patient Name (Print) _____ DOB: _____

Signature: _____ Date: _____

# Innovative Health and Wellness

**Consent for Testosterone Replacement/ HCG Therapy/ No Other Therapy Agreement**

**Patient Name: _____ DOB: _____**

**A FEW THINGS TO KNOW ABOUT TESTOSTERONE REPLACEMENT/HCG THERAPY (TRT)**

It is important to understand that medicine is an inexact science. Although we will carry out your treatment carefully, results may vary in their degree of success. It is quite natural for a patient undergoing Testosterone Replacement Therapy to want to know that everything will turn out all right. While most of the time this is the case, it is very important for you to be aware of the potential risks, as well as the benefits, expected from the treatment when deciding on whether to begin Testosterone Replacement Therapy. You should also be aware of the alternatives to Testosterone Replacement Therapy, including not receiving the treatment. It is important that you consider the information we have provided you. Be sure that you are doing what is right for you. If you are unsure, then perhaps you should take some time to weight your options or consult another health care provider. Please review the following statements, which discuss informed consent. Any questions that you may have should be brought to our attention. Your clinical provider will attempt to answer all your questions to your satisfaction.

**Directions: Initial beside each statement that you have read, understand and agree with.**

_____**1.** This is my consent for Innovative Health and Wellness, including any physician or nurse who works with the company, to begin my treatment for Testosterone Replacement Therapy.

_____2. It has been explained to me, and I fully understand, that occasionally there are complications with this treatment such as Acne, Breast Enlargement, Mood Swings, as well as the following (#3-#7)

_____3. Extra fluid in the body- This can cause problems for patients with heart, kidney or liver disease.

_____4. Sleep disturbance- This is called sleep apnea and is more likely to occur with patients who have lung disease or are overweight.

_____5. Prostate enlargement- this may cause problems with urinating.

_____6. Changes in cholesterol levels, red blood cell levels, PSA levels, liver function enzymes, and other hormone levels which will be monitored with periodic blood tests.

_____7. I understand that I will have periodic blood tests to monitor my blood levels.

_____8. I understand there is no guarantee as to the result and that if I stop treatment, my condition may return or get worse.

_____9. I have had an opportunity to discuss with Innovative Health and Wellness and its medical practitioners my complete past medical and health history including any serious problems and/or injuries. All of my questions concerning the risks, benefits and alternatives have been answered. I am satisfied with the answers.

_____10. I understand that the physical exam by Innovative Health and Wellness does NOT replace a full physical exam by a personal physician.

_____11. I agree to have my personal physician perform a yearly full physical exam including a digital rectal exam, lipid profile, cholesterol levels and a comprehensive metabolic panel. If I do not have a personal physician, Innovative Health and Wellness will assist in locating one for me.

_____12. I understand that prolonged TRT therapy may reduce ejaculate volume and reduce sperm count, possibly affecting fertility.

I, _____, agree that, while a patient of Innovative Health and Wellness, I will not take any type of anabolic steroids, testosterone gels, hormone "boosters," pro-hormones or any additional testosterone supplementation not provided by Innovative Health and Wellness during my treatment plan. At any time, if use of these items is discovered, I understand I may be discharged as a patient of Innovative Health and Wellness.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

## ADAM questionnaire about symptoms of low testosterone

(Androgen Deficiency in Aging Male)

**This basic questionnaire can be very useful for men to describe the kind and severity of their low testosterone symptoms.**

| | | | |
|---|---|---|---|
| 1. | Do you have a decrease in libido (sex drive)? | Yes | No |
| 2. | Do you have a lack of energy? | Yes | No |
| 3. | Do you have a decrease in strength and/or endurance? | Yes | No |
| 4. | Have you lost height? | Yes | No |
| 5. | Have you noticed a decreased "enjoyment of life" | Yes | No |
| 6. | Are you sad and/or grumpy? | Yes | No |
| 7. | Are your erections less strong? | Yes | No |
| 8. | Have you noticed a recent deterioration in your ability to | Yes | No |
| 9. | Play sports? | | |
| 10. | Are you falling asleep after dinner? | Yes | No |
| 11. | Has there been deterioration of your work performance? | Yes | No |

**If you answered yes to number 1 or 7 or if you answer yes to more than 3 questions, you may have low Testosterone.**

### ADDITIONAL INFORMATION

List all medications you are taking now including over the counter medication:

_____

_____

Do you have or have you ever had any diseases or medical problems not listed? If so, please list:

_____

I have read the above information and certify that it is to be true and correct to the best of my knowledge, and hereby authorize this office to provide care, in accordance with state's statutes.

Patient or Guardian Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

295 Molly Lane, Suite 150
Woodstock, GA 30189
Phone: 770-926-4646
Fax: 770-966-8870

3115 Piedmont Rd, Suite A102
Atlanta, GA 30305
Phone: 404-816-0222
Fax: 404-464-7699

# ALLERGY IMPACT QUESTIONNAIRE

Patient's Name: _____ DOB: _____

**Please answer all questions fully and circle all answers that apply.**

- Do you think you suffer from allergies? Yes No
- Are the symptoms Year Long? Yes No Seasonal? Yes No
- How long are your symptoms per week? Less than 7 days All 7 days
- What time of the day are your symptoms worse? Morning Afternoon Night All day
- Are the symptoms worse in the spring, fall, or both? Spring Fall Both
- Do you have any sinus drainage issues? Yes No If Yes, when? AM PM All day
- Do you ever have watery or itchy eyes? Always Most Times Sometimes Never
- Do you cough or sneeze on a regular basis? Yes No If Yes, when? _____
- Do you have regular upper respiratory infections? Yes No If Yes, Less than 3 OR More than 3 per year
- Do you think you might be allergic to animals? Yes No
- Have you been diagnosed with asthma? Yes No If yes, when? _____
- Do you have a family history of asthma? Yes No
- How long have you lived in Georgia? _____ Years _____Months
- How long have you lived in your current residence? _____Years _____Months
- Did you have allergies in your previous residence or state? Yes No
- Do you wear a mask when you cut grass? Yes No
- Do you have a HEPA filter on your vacuum cleaner? Yes No
- Do you use an inhaler? Yes No
- Are you currently using any allergy medications? Yes No If yes, please list all medications including over the counter medications _____
- Are you currently taking any blood pressure medications? Yes No If yes, please list:
  _____ _____ _____

**Patient's Signature_____ Date_____**

**Office Staff Use Only: ICD 10 Codes For Patient: Medical Provider Please Circle All That Apply**
**H10.45 H65.90 J30.2 J30.81 J30.1 R21 T78.1XXA _____ Other**

**Based on these results and examination, I certify that allergy testing is indicated for the above-named patient and so ordered.**
**Physician's Signature:_____Date: _____**

# Patient Missed Appointment Policy

**Definitions**: Policy- a way of managing affairs so as to achieve some purpose.

Appointment - a meeting with someone at a certain time and place.

Missed- fail to keep, or be present at.

It is our wish that each and every one of our patients receive the very best care and service possible. Your treatment program consists of a specific series of treatment given over a pre-planned time span. If you do not follow this plan, then you will not receive the desired results.

1. Meet all your appointments. Arrange the activities in your life so that this can occur.
2. If you become ill, we still want you to come in, because treatment will help you recover.
3. If you are unable to make it in due to an emergency, please call us and let us know so we can schedule your appointment.
4. With exceptions of unexpected emergencies, we require that you notify us at least 24 hours in advance as to any appointment changes.
5. All cancelled or missed appointments must be rescheduled and made up within the week.
6. We have the right to charge 5.00 for no call/no show appointments.
7. There could also be a $20.00 charge for missing an appointment with the medical doctor.

**I have read, understand, and agree to follow the above policy.**

**Patient's Name: _____ DOB: _____**

**Signature: _____ Date: _____**

**Staff Witness: _____**

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HEALTH AND WELLNESS

**FINANCIAL RESPONSIBLITIES**

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. I authorize payment directly from my insurance company to Innovative Health and Wellness. Furthermore, I understand that this office will prepare nay necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are ultimately my personal responsibility. I also understand that if I suspend or terminate my care and treatment any fees for professional service rendered to me will be immediately due and payable.
If I have insurance, I am responsible for my insurance deductible, co-payments and any service rejected by my insurance company. I am also aware that is I have not made a payment on my outstanding balance within a 30 day period, a service fee of 2% will be added to my account. If I have an outstanding balance that may be served to a collection agency, there will be an additional fifty dollar fee added.
This office cannot promise that an insurance company will pay. In the event that the insurance company disputes or rejects the claim, we will pursue on your behalf as far as we are able to. If unsuccessful, you will be expected to take responsibility for any outstanding balance.
I authorize this clinic to release any information pertinent to my case to any insurance company, adjuster and/or attorney involved in this case, and herby release this clinic of any consequences thereof.
Although our office will call to verify your insurance coverage, it is your responsibility to confirm and know your benefits. If you have limited coverage, you need to be aware of when your insurance will stop paying your claims.
I certify that the information provided in this three part form is correct to the best of my knowledge. I will not hold my doctor or any staff member of Innovative Health and Wellness responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient: _____ Date: _____

Patient Name (print)_____ D.O.B._____

Signature of Parent/ Guardian: _____ Date: _____

**ACKNOWLEDGEMENT AND UNDERSTANDING**

I acknowledge and agree to the following:
The doctor will not be held responsible for any pre-existing medically diagnosed conditions.
Chiropractic is not a treatment for any condition or symptom. It is a care system that is aimed toward the reduction and correction of spinal subluxations so that your body as a whole may function better.
Although Chiropractic care is one of the safest forms of health care, it is associated with some minor risks and it is my responsibility to be informed about those risks by asking the doctor or a staff member prior to treatment.
Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a care for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another health care professional who we feel can further assist you.
I hereby authorize the doctors and staff affiliated with Innovative Health and Wellness treat my condition as deemed appropriate.

Signature of Patient: _____ Date: _____

Signature of Parent/ Guardian: _____ Date: _____

**CONSENT OF TREATMENT OF A MINOR CHILD**

I hereby authorize Dr. Orlando and whomever he may designate as assistance to administer chiropractic care as deems necessary to my _____ (indicate relationship to minor).

Name of Minor: _____ Date: _____

Signature of Parent/ Guardian: _____

Signature of Staff: _____ Date: _____

# Assignment of Health Plan Benefits and Rights as well as an Appointment as an ERISA*/PPACA** Representative Designation

I understand and agree that, regardless of whatever health insurance or medical benefits I have, I am ultimately responsible to pay **Innovative Health and Wellness, LLC** the balance due on my account for any professional medical and chiropractic services rendered and for any ancillary supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to **Innovative Health and Wellness, LLC** for medical/healthcare services rendered and for any ancillary supplies, tests, and medications provided.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, of to pursue any other remedies necessary in connection with same.

I hereby assign directly to **Innovative Health and Wellness, LLC** all rights to payments, benefits, and all other legal rights under, or pursuant to, any health plan, ERISA plan, PPACA plan, or insurance contract rights that I (or my child, spouse, or dependent) may have under my/our applicable health plans(s) or health insurance policy(ies). This assignment includes, but not limited to, a designation that **Innovative Health and Wellness, LLC** can act on my/our behalf, as my/our representative, ERISA representative, or PPACA representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to **Innovative Health and Wellness, LLC** as a result of services rendered by **Innovative Health and Wellness, LLC** and to pursue any and all remedies to which I/we may be entitles, including the use of legal action against the health plan or insurer. This assignment and designation remains in effect unless revoked in writing and a photocopy or scan is to be considered as a valid and enforceable as the original.

**Assignment of Insurance Benefits:** I hereby authorize payment to be made directly to PROVIDER'S OFFICE of all benefits which may be due and payable under insurance coverage for the undersigned patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to PROVIDER'S OFFICE.
Furthermore, I hereby **IRREVOCABLY ASSIGN to PROVIDER'S OFFICE**, the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in the state, Georgia statutes for any service and/or charges provided by PROVIDER'S OFFICE

Signed this _____day of _____20___

_____ _____

Patient Signature Office Staff Signature

_____

Patient's Printed Name

_____

Signature of Guardian (if applicable)

*ERISA – Employee Retirement Income Security Act
**PPACA – Patient Protection and Affordable Care Act

Innovative
HEALTH AND WELLNESS

**HIPAA**

**PATIENT CONSENT FORM**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient's 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 that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care 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).

The patient understands that:

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

This consent was signed by: _____D.O.B._____
Printed name of Patient or Representative

Signature: _____ Date: _____


295 Molly Lane. Suite #150
Woodstock, GA 30189

3115 Piedmont Road, A102
Atlanta GA 30305

# ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____DOB_____

I hereby acknowledge that I received the Notice of Privacy Practices statement of Innovative Health and Wellness, LLC

Signature: _____ Date: _____