SYNERGY

An Integrative Medical Center

Ph: (757) 410-5462

Patient Information Form For Men

NAME: _____

ADDRESS: _____

_____

_____

HOME TELEPHONE: (_____)_____

CELLULAR TELEPHONE: (_____)_____

WORK TELEPHONE: (_____)_____

EMAIL ADDRESS: _____

BIRTHDATE: _____/_____/_____

NAME OF PRIMARY CARE PHYSICIAN: _____

EMERGENCY CONTACT: _____ **PHONE:**_____

REASON FOR VISIT: _____

How did you hear about us (please check):
Wife _____ **Internet**_____ **Friend**_____ **Other** _____

Synergy Integrative Medical Center
Patient Intake form for Men

MR# _____

Name _____ age_____ Date _____

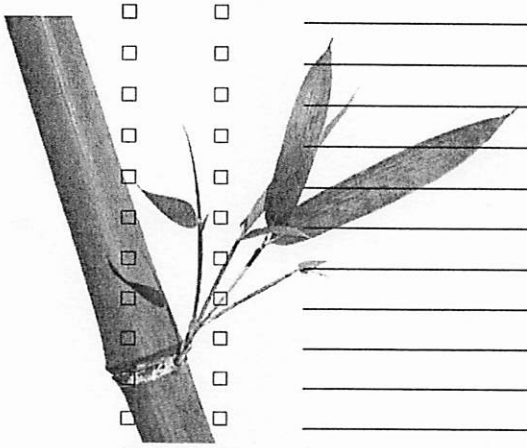
Primary Care Doctor _____ Referred by _____

Concern(s): Please rank by priority Example: Headaches	Onset 2 years ago	Frequency 2x/wk	Severity mild/mod/severe
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

What are your goals for this visit? _____
_____
_____
_____

Illnesses – yours & your family's

	Self	Family	List family members who have had these illnesses
Heart Disease	☐	☐	_____
High blood pressure	☐	☐	_____
Cancer	☐	☐	_____
Stroke	☐	☐	_____
Diabetes	☐	☐	_____
Lung disease	☐	☐	_____
Hepatitis	☐	☐	_____
Digestive diseases	☐	☐	_____
Seizures	☐	☐	_____
Thyroid disease	☐	☐	_____
Mental disorders	☐	☐	_____
Osteoporosis	☐	☐	_____
Other _____	☐	☐	_____
Other _____	☐	☐	_____



Have you fathered any pregnancies? _____ yes ____ no

Is infertility a concern for you? _____ yes ____no

Operations		**Injuries**	
What	When	What	When

Please list all medications, vitamins, herbs and supplements which you now take regularly, prescribed or over-the-counter.

Name & dosage	Reason	When started	Who recommended

Allergies or intolerances to medicines:

Medication	Reaction/intolerance symptoms

Occupation, or previous occupation if retired: _____

What interests/hobbies do you have? _____

_____

_____

With whom do you live?

Name	Age	Relationship	Name	Age	Relationship

What physical activity do you do? _____

_____

What are the major stressors in your life? _____

_____

_____

What do you do to relax? (or what would you like to do?) _____

_____

_____

Religious affiliation _____

What prior experiences have you had with complementary and alternative medicine? _____

_____

_____

Tobacco use: □ never used □smoked from age ___ to ___ . ____ packs per day.

Alcohol use: □ never used □estimated ____ drinks per week.

□ history of alcohol abuse

Recreational drugs: □ never used □ type _____

Health screening:

Have you had?	No	Yes	Date of most recent	Who ordered/performed
PSA				
Colonoscopy				
Prostate exam				
Bone density test				
Cholesterol test				

Review of symptoms:

Sleep _____ hrs/night sleep problems _____do you have sleep apnea? y n

Hair problems _____

Erection problems/impotence/ED y n

Do you have erections while sleeping or in the morning? y n

Other sexual problems (list) _____

Intolerance to heat or cold (circle if applicable)

Fatigue y n

Dry skin y n

Frequent or severe headaches y n

Weight loss y n Weight gain y n

Swelling y n describe _____

Palpitations y n

Breast enlargement y n

Frequent crying or depression y n

Weakness y n

Joint pain y n

Muscle problems y n

Stomach/bowel problems y n describe _____

Urinary problems y n describe _____

Nutrition Evaluation

Dietary intake. Please list **all** food and drinks you have consumed in the past 24 hours. Be honest – don't write what you think we want to hear. You're only hurting yourself.

Food or drink **how prepared (baked, fried, etc)** **amount (cups, tbsp, ounces, etc)**

Any food you avoid, and why _____

Was this a typical day? If not, why not? _____

ED Questionnaire for Men

Each question has several possible responses. Circle the number of the responses that best describes your own situation. Please be sure that you select one response for each question.

OVER THE PAST 6 MONTHS:

How do you rate your confidence that you could get and keep an erection?		**Very Low**	**Low**	**Moderate**	**High**	**Very High**
		1	2	3	4	5
When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?	**No sexual activity**	**Almost Never or Never**	**A Few Times (much less than half the time)**	**Sometimes (about half the time)**	**Most Times (much more than half the time)**	**Almost Always or Always**
	0	1	2	3	4	5
During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	**Do not attempt intercourse**	**Almost Never or Never**	**A Few Times (must less than half the time)**	**Sometimes (about half the time)**	**Most Times (much more than half the time)**	**Almost Always or Always**
	0	1	2	3	4	5
During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	**Do not attempt intercourse**	**Extremely Difficult**	**Very Difficult**	**Difficult**	**Slightly Difficult**	**Not Difficult**
	0	1	2	3	4	5
When you attempted sexual intercourse, how often was it satisfactory for you?	**Do no attempt intercourse**	**Almost Never or Never**	**A Few Times (much less than half the time)**	**Sometimes (about half the time)**	**Most Times (much more than half the time)**	**Almost Always or Always**
	0	1	2	3	4	5

Add the numbers: TOTAL_____

The Sexual Health Inventory for Men further classifies ED severity with the following breakpoints:

1 – 7 Severe ED
8 – 11 Moderate ED
12 – 16 Mild to Moderate ED
17 – 21 Mild ED

Consent For Hormone Supplementation Therapy

I request and consent to the administration of hormones and oral supplements and authorize that these will be prescribed by the physicians of Synergy Medical Center. I acknowledge that there are no guarantees or assurances made with respect to the benefit of Hormones Supplementation Therapy prescribed for me.

I understand that I will be in charge of administering these hormones and supplements prescribed to me. I will conform and comply with the recommended doses and methods of administration.

I understand that initial blood tests must and will be performed to establish my baseline hormone level. I agree to comply with requests for ongoing testing to assure proper monitoring of my hormone levels. I agree to communicate with the physicians at Synergy Medical Center , any adverse reaction or problems that might be related to my Hormone Therapy. I understand that with Hormone Supplementation, there are possible risks and complications, if I do not comply with the recommended dosage.

I have not been promised or guaranteed any specific benefit from the administration of this therapy. I understand that Hormone Supplementation for rejuvenation purposes is a new specialty and there are no guarantees with respect to the treatment prescribed.

I understand that the role of the physicians of Synergy Medical Center is for Hormone Replacement Therapy Supplementation only, and that I agree I am and will be under the care of another physician for all other medical conditions. Synergy physicians are available during daytime working hours only.

I have been informed that insurance companies and Medicare do not pay for Hormone Replacement Therapy: I therefore agree to pay Synergy Medical Center and any pharmacy charges myself, with the understanding that I will not be reimbursed by my insurance company.

I have read and understood all of the above consent conditions. I have had other information given to me about Hormone Supplementation Therapy, so that I fully understand what I am signing and hereby request and consent to treatment using Hormone Supplementation Therapy.

_____ _____

Patient Signature Date

_____ _____

Physician Signature Date

Medical Appointment Cancellation Policy

Dear Patient,

Synergy Integrative Medicine strives to render excellent medical care to you and all of our patients. In order to be consistent with this philosophy, Synergy uses an appointment system that sets aside time for a patient dependent on that patient's need. When you do not show up for your appointment or notify us of your inability to keep your appointment at least 24 hours in advance, the time that has been allotted for your visit cannot be used to treat another patient and is time lost to our office. With that in mind and in order to have time available for all patients, a Medical Appointment Cancellation Policy has been put into place.

Our policy is as follows:

We request that you please give our office a 24 hour notice in the event that you need to reschedule your appointment. This also makes it possible to reschedule your appointment more efficiently. If a patient misses an appointment and does not contact us with at least a 24 hour notice, we consider this to be a missed appointment, "No Show, No Call", and the following fees will be accessed:

BHRT follow up appointments (30 minutes)	$100.00
BHRT 1 year follow up appointments (1 hour)	$175.00
Wellness follow up appointments (30 minutes)	$100.00
Wellness 1 year follow up appointments (1 hour)	$150.00

As a courtesy, we do make reminder calls for appointments. If you do not receive your message or we have incorrect information, the cancellation policy will still be in effect.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you may have.

We thank you for your patronage.

I have read and understand the Medical Appointment Cancellation Policy of the practice and agree to be bound by its terms. I also understand that this notice may be changed at any time by the practice.

Printed Name of the Patient	**Relationship to Patient (if patient is a minor)**
Signature of Patient or Responsible Party	**Date**

Synergy – An Integrative Medicine Center for Women, PLC
1036 Volvo Parkway, Suite 2
Chesapeake, VA 23320

Telephone Number 757.410.5462
Facsimile Number 757.410.5862

Telemedicine Informed Consent Form

I _____, consent to engaging in telemedicine with Synergy – An Integrative Medicine Center for Women, PLC. I understand that telemedicine may include health evaluation, assessment, consultation, treatment planning, and therapy. Telemedicine will occur primarily through interactive audio, video, telephone and/or other audio/video communications.

Permissible telemedicine services available to me include prescription refills, appointment scheduling and patient education.

I understand that the provider is responsible for determining whether or not the condition or conditions being diagnosed during this telemedicine encounter is appropriate for this form of interaction/communication.

I understand I have the following rights with respect to telemedicine:

- I have the right to withhold or remove consent at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.

- The laws that protect the confidentiality of my personal information also apply to telemedicine. As such, I understand that the information released by me during the course of my teleconference/consultation is generally confidential. Both mandatory and permissive exceptions to confidentiality exist including but not limited to legal proceedings where information is requested by a court of law. I also understand that the dissemination of any personally identifiable images or information from the telemedicine consultation to other entities shall not occur without my written consent,

- I understand that telemedicine-based services and care may not be as complete and in-person services. I understand that if my provider believes I would be better served by other interactions, that I will be referred to a provider who can provide those services in my area. I also understand that there are potential risks and benefits associated with any form of health treatment, and that despite my efforts and efforts of my provider, my condition may not improve, or may have the potential to get worse.

- I understand that I may benefit from telemedicine services, but that results cannot be guaranteed or assured. I understand that the use of Skype, Facetime, GoToMeeting, and

Google audio/video systems are not 100% secure and may have issues with wifi connectivity. All attempts to keep information confidential while using these systems will be made but a guarantee of 100% confidentiality cannot be made with inherent issues with these communication systems. Signing this form reflects my awareness of these issues and a decision by me to use these systems for telemedicine services. To that end, I understand and agree that my provider and Synergy - An Integrative Medicine Center for Women have taken reasonable security measures to protect my personal health information such as, by way of example but not by limitation, date of service encryption, password-protected screen savers, encrypted data files, and other reasonable and reliable authentication techniques. I will not hold Synergy - An Integrative Medicine Center for Women, PLC, or its staff liable for and thereby indemnify the provider and Synergy - An Integrative Medicine Center for Women, PLC, against gathering or use of client information by these service providers and against information lost due to technical failures.

- I understand that certain risks unique and specific to telemedicine, including but not limited to, the possibility that telemedicine consultations or other communications by my provider to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons.

I understand I have the right to access my personal information. I have read and understand the information provided above. I expressly consent to the forwarding of information that identifies me as a patient to third parties. I have discussed these points with my provider, and all of my questions regarding the above matters have been answered to my approval.

By signing this document, I agree that certain situations specifically inclusive of emergencies are inappropriate for audio/video/computer based medical services. If I am in an emergency situation, I should immediately call 911 or go to the nearest hospital.

Signature of client/parent/guardian	Date
Printed name of client/parent/guardian	Relationship (If applicable)
Provider Name	Provider Credentials

1036 VOLVO PARKWAY Suite 2 CHESAPEAKE, VA 23320 tel 757.410.5462

DATE: _____

THIS IS TO ACKNOWLEDGE THAT I HAVE BEEN GIVEN THE OPPORTUNITY TO READ AND REVIEW THE "NOTICE OF PRIVACY PRACTICES" OF SYNERGY, AN INTEGRATIVE MEDICINE CENTER, PLC.

I ALSO ACKNOWLEDGE THAT UPON REQUEST I WILL BE PROVIDED WITH A COPY OF THE POLICIES.

PATIENT'S SIGNATURE: _____

PATIENT'S NAME: _____

(PLEASE PRINT)

Notice of Privacy Practices

Synergy Integrative Medical Center

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Our Duty to Safeguard Your Protected Health Information.

We understand that medical information about you is personal and confidential. Be assured that we are committed to protecting that information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. We are required by law to abide by the terms of this Notice, and we reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice and make paper and electronic copies of this Notice of Privacy Practices for Protected Health Information available upon request. We are required by law to notify you in the event of a breach of your protected health information.

In general, when we release your personal information, we must release only the information needed to achieve the purpose of the use or disclosure. However, all of your personal health information that you designate will be available for release if you sign an authorization form, if you request the information for yourself, to a provider regarding your treatment, or due to a legal requirement. We will not use or sell any of your personal information for marketing purposes without your written authorization.

II. How We May Use and Disclose Your Protected Health Information.

For uses and disclosures relating to treatment, payment, or health care operations, we do not need an authorization to use and disclose your medical information:

For treatment: We may disclose your medical information to doctors, nurses, and other health care personnel who are involved in providing your health care. We may use your medical information to provide you with medical treatment or services. For example, your doctor may be providing treatment for a heart problem and need to make sure that you don't have any other health problems that could interfere. The doctor might use your medical history to determine what method of treatment (such as a drug or surgery) is best for you. Your medical information might also be shared among members of your treatment team, or with your pharmacist(s).

To obtain payment: We may use and/or disclose your medical information in order to bill and collect payment for your health care services or to obtain permission for an anticipated plan of treatment. For example, in order for Medicare or an insurance company to pay for your treatment, we must submit a bill that identifies you, your diagnoses, and the services provided to you. As a result, we will pass this type of health information on to an insurer to help receive payment for your medical bills.

For health care operations: We may use and/or disclose your medical information in the course of operating our practice. For example, we may use your medical information in evaluating the quality of services provided or disclose your medical information to our accountant or attorney for audit purposes.

In addition, unless you object, we may use your health information to send you appointment reminders or

information about treatment alternatives or other health related benefits that may be of interest to you. For example, we may look at your medical record to determine the date and time of your next appointment with us, and then send you a reminder to help you remember. Or, we may look at your medical information and decide that another treatment or a new service we offer may interest you.

We may also use and/or disclose your medical information in accordance with federal and state laws for the following purposes:

- We may disclose your medical information to law enforcement or other specialized government functions in response to a court order, subpoena, warrant, summons, or similar process.
- We may disclose medical information when a law requires that we report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. We must also disclose medical information to authorities who monitor compliance with these privacy requirements.
- We may disclose medical information when we are required to collect information about disease or injury, or to report vital statistics to the public health authority. We may also disclose medical information to the protection and advocacy agency, or another agency responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
- We may disclose medical information relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
- In certain circumstances, we may disclose medical information to assist medical/psychiatric research.
- In order to avoid a serious threat to health or safety, we may disclose medical information to law enforcement or other persons who can reasonably prevent or lessen the threat of harm, or to help with the coordination of disaster relief efforts.
- If people such as family members, relatives, or close personal friends are involved in your care or helping you pay your medical bills, we may release important health information about your location, general condition, or death.
- We may disclose your medical information as authorized by law relating to worker's compensation or similar programs.
- We may disclose your medical information in the course of certain judicial or administrative proceedings.

Other uses and disclosures of your medical information:

State Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Electronic Patient Chart Sharing: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Treatment Alternative: We may provide you notice of treatment options or health related services that improve your overall health.

Appointment Reminders: We may contact you as a reminder about upcoming appointments or treatment.

The following uses and disclosure of PHI require your written authorization:

- Marketing
- Disclosures for any purposes which require the sale of your information
- Release of psychotherapy notes: Psychotherapy notes are the notes by a mental health professional for the purposes of documenting a conversation during a private session. This session could be with an individual or a group. These notes are kept separate from the rest of the medical record and

do not include; medications and how they affect you, start and stop time of sessions, types of treatments provided, results of test, diagnosis, treatment plan, symptoms, prognosis.

Other uses and disclosures of PHI not covered by this Notice, or by the laws that apply to us, will be made only with your written authorization. If you provide permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided you.

III. Your Rights Regarding Your Medical Information.

You have several rights with regard to your health information. If you wish to exercise any of these rights, please contact our Medical Records Department in our office. Specifically, you have the following rights:

- **Right to Request Restrictions** - You have the right to ask that we limit how we use or disclose your medical information. We require that any requests for use or disclosure of medical information be made in writing. Written notice must be sent to the attention of the Office Manager at the practice and address indicated in the header of this Notice. We will consider your request, but in some cases, we are not legally required to agree to these requests. However, if we do agree to them, we will abide by these restrictions. We will always notify you of our decisions regarding restriction requests in writing. We will not ask you the reason for your request. For example, for services you request no insurance claim be filed and for which you pay privately, you have the right to restrict disclosures for these services for which you paid out of pocket. You have the right to ask that we send you information at an alternative address or by alternative means. Your request must specify how or where you wish to be contacted. You have the right to opt out of communications for fundraising purposes.

- **Right to Access, Inspect and Copy** - With a few exceptions (such as psychotherapy notes or information gathered for judicial proceedings), you have a right to inspect and copy your protected health information if you put your request in writing. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. We may charge you a reasonable fee if you want a copy of your health information. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying. Consent is required prior to use or disclosure of an individual's psychotherapy notes or the use of the individuals PHI for marketing purposes.

- **Right to Amend** - If you believe that there is a mistake or missing information in our record of your medical information you may request that we correct or add to the record. Your request must be in writing and give a reason as to why your health information should be changed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your medical information. If we approve the request for amendment, we will amend the medical information and so inform you.

- **Right to an Accounting of Disclosures** - In some limited circumstances, you have the right to ask for a list of the disclosures of your health information we have made during the previous six years. The list will not include disclosures made to you; for purposes of treatment, payment or healthcare operations, for which you signed an authorization or for other reasons for which we are not required to keep a record of disclosures. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

- **Right to a Paper Copy of This Notice** - You have a right to receive a paper copy of this Notice and/or an electronic copy from our Web site. If you have received an electronic copy, we will provide you with a paper copy of the Notice upon request.

IV. Our Responsibilities:

- We are required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time and notify us in writing.

Questions and Complaints:

If you want more information about our privacy practices or have questions or concerns, we encourage you to contact us.

If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, we encourage you to speak or write to our Privacy Officer.

If you have questions about this Notice or any complaints about our privacy practices, please contact:

Office of the HIPAA Privacy and Security Officer

Phone: (757) 410-5462
1036 Volvo Parkway, Suite 2
Chesapeake, VA 23320

If you want more information about our privacy practices or have questions or concerns, we encourage you to contact us.

If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, we encourage you to speak or write to our Privacy Officer.

You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services at the Office for Civil Rights' Region IV office.

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201
Email to OCRComplaint@hhs.gov

We will take no retaliatory action against you if you make complaints, whether to us or to the Department of Health and Human Services. We support your right to the privacy of your health information.

VI. Effective Date:

This Notice was effective on January 1, 2019.