Male New Patient Packet

The contents of this package are your first step to restoring your vitality.

Please take time to read this carefully and answer all the questions as completely as possible.

We look forward to partnering with you to help you feel your best again.

Male Patient Questionnaire & History

Name: _____ Today's Date: _____
(Last) (First) (Middle)

Date of Birth: _____ Age: _____ Occupation: _____

Home Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-Mail Address: _____

In Case of Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Primary Care Physician's Name: _____ Phone: _____

Address: _____
Street City State Zip

Medical History

Current Medications: _____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Nutritional/Vitamin Supplements: _____

Date of Last Physical: _____

Personal Medical History

( ) High blood pressure
( ) High cholesterol
( ) Heart Disease
( ) Stroke and/or heart attack
( ) Blood clot and/or a pulmonary emboli
( ) Hemochromatosis
( ) Depression/anxiety
( ) Psychiatric Disorder
( ) Cancer (type): _____
Year: _____

( ) Testicular or prostate cancer
( ) Elevated PSA
( ) Prostate enlargement
( ) Trouble passing urine or take Flomax or Avodart
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis)
( ) Diabetes
( ) Thyroid disease
( ) Arthritis

Any known drug allergies: _____

Have you ever had any issues with anesthesia? ( ) Yes ( ) No
If yes please explain: _____

Surgeries, list all and when: _____

Family History:
( ) High Blood Pressure
( ) Diabetes
( ) Heart Disease
( ) Stroke
( ) Cancer: _____

Number of siblings: _____ How many brothers? _____ Sisters? _____
Number of children: _____ How many sons? _____ Daughters? _____

Social:
Marital Status: ( ) Married ( ) Divorced ( ) Widower ( ) Living with Partner ( ) Single

Sexual Preference: ( ) Male ( ) Female ( ) Both

( ) I am sexually active.
( ) I want to be sexually active.
( ) I have completed my family.
( ) I have used steroids in the past for athletic purposes.

Habits:
( ) I smoke cigarettes or cigars _____ a day.
( ) I drink alcoholic beverages _____ per week.
( ) I drink more than 10 alcoholic beverages a week.
( ) I use caffeine _____ a day.

Other Pertinent Information: _____
_____

I understand that if I begin testosterone replacement with any testosterone treatment, including testosterone pellets, that I will produce less testosterone from my testicles and if I stop replacement, I may experience a temporary decrease in my testosterone production. Testosterone Pellets should be completely out of your system in 12 months.

By beginning treatment, I accept all the risks of therapy stated herein and future risks that might be reported. I understand that higher than normal physiologic levels may be reached to create the necessary hormonal balance.

_____ _____ _____
Print Name **Signature** **Today's Date**

BHRT CHECKLIST FOR MEN

Symptom *(please check mark)*	Never	Mild	Moderate	Severe
Decline in general well being (general state of health)				
Joint pain/muscle ache (lower back/joint/limb pain)				
Excessive sweating (sudden episodes/hot flash)				
Sleep problems (difficulty falling/staying asleep/wake up tired)				
Increased need for sleep (feel tired often)				
Irritability (aggressive/easily upset/moody)				
Nervousness (inner tension/restlessness)				
Anxiety (feeling panicky)				
Depressed mood (feeling down/sad/lack of drive/nothing of any use)				
Exhaustion/lacking vitality (decreased performance & activity/lack of interest/motivation)				
Declining Mental Ability/Focus/Concentration				
Feeling you have passed your peak				
Feeling burned out/hit rock bottom				
Decreased muscle strength				
Weight Gain/Belly Fat/Inability to Lose Weight				
Breast Development				
Shrinking Testicles				
Rapid Hair Loss				
Decrease in beard growth				
New Migraine Headaches				
Decreased desire/libido				
Decreased morning erections				
Decreased ability to perform sexually				
Infrequent or Absent Ejaculations				
No Results from E.D. Medications				
Other symptoms that concern you:				

INFORMED CONSENT FOR BLOOD WORK, GENETIC TESTING, AND VACCINES

Your lab work and/or vaccines may or may not be covered by your insurance plan or Medicare/Medicaid. **You are responsible for determining insurance coverage for these tests and for any payments to outside laboratories or facilities. Even if these tests are covered, charges may apply towards your copay or deductible. We do not verify coverage or benefits for these services.** Additional tests may also be added at the provider's discretion if abnormal results are returned.

I have read the information above and understand its content. I understand that I may ask questions about testing at any time. I hereby give my consent to have my blood drawn or tissue samples collected for the labs discussed with the provider, or to receive the vaccine(s) recommended.

Print name:_____ Signature:_____ Date:_____

CONFIDENTIAL COMMUNICATIONS REGARDING YOUR HEALTH INFORMATION

The confidentiality of your personal health information is of the utmost importance to our office. Please indicate below any requests for restrictions on how we may communicate your personal health information and/or billing information. If this form is left blank, our office will only disclose information to you.

Name(s) of person(s) who are permitted to discuss your personal health information and/or billing information:

_____ _____

This authorization will remain valid one year from the date listed below. It is the responsibility of the patient to notify the office of any changes to this information.

Print name:_____ Signature:_____ Date:_____

CONSENT FOR TREATMENT

I authorize and direct Lisa M. Jukes, M.D. and her providers/mid-level providers (nurse practitioner/physician assistant)/assistants to perform quality care, including, but not limited to: diagnostic procedures and surgical and medical treatment(s), as may be necessary in their professional judgement.

I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the outcome of the procedures and/or treatments.

I acknowledge that, when medically appropriate, I may receive care from a mid-level provider or assistant.

I grant this consent without duress, confusion, or pressure from Lisa M. Jukes, M.D. and/or her staff, associates, or colleagues.

Print name:_____ Signature:_____ Date:_____

HIPAA NOTICE OF PRIVACY PRACTICES

Effective, April 14th, 2003; Updated January 17th, 2014

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related healthcare services.

1. Use and Disclosure of Protected Health Information Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other use required by law.
Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.
Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital administration.
Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities, employee review activities, training of medical students, licensing, marketing, and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. The situations include: as required by law; public health issues as required by law; communicable diseases; health oversight, abuse, or neglect; Food and Drug Administration requirements, legal proceedings, law enforcement, coroner, funeral directors, organ donation, research, military activity and national Security, Worker's Compensation. Under the law, we must make disclosures to you and when required by the Secretary of the Department on Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.
Other permitted uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance or on the use or disclosure indicated in the authorization.

2**.Your Rights** Following is a statement of your rights with respect to your protected health information.
You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.
You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notification of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your physician is not required to agree to a restriction you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.
You have the right to request confidential communications from use by alternative means or at an alternative location.
You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.
You have the right to request your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

3.Complaints You may complain to use or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against your for filing a complaint.**

Signature below is only acknowledgement that you have received this Notice of Privacy Practices.

Print Name:_____ **Signature:**_____ **Date:**_____

FINANCIAL POLICY

1. **All payments are required at the time services are rendered.** If we are in network with your insurance company your copay, unmet deductible and/or coinsurance must be paid at the time of service. These amounts are only estimates of total financial responsibility and you may still be billed for additional amounts after the claim for your visit has been finalized. Federal law requires that we collect copays at the time of service; otherwise we can be charged with fraudulent business practices. Patients who may have difficulty paying at the time of service should ask about payment options you may be eligible for. All payment arrangements must be made prior to services being rendered.

   It is the patient's responsibility to know whether or not the provider of service is in network. The agreement with your insurance company is a contract between you and the insurance company. Please call the number on the back of your insurance card for this information. If we are not in network with your insurance or if you fail to get the necessary referral or authorization to see our providers, you will be responsible for the difference between physician charges and any out-of-network payments. If your plan states that you need a referral to see Dr. Jukes, it is your responsibility to obtain the referral from your primary care physician or insurance carrier, depending on your plan benefits, prior to services being rendered.

   Non-preventive concerns addressed at a wellness visit may not be covered in full. While many insurance plans cover well woman exams in full, any existing problems addressed at the same visit may be subject to copays and/or deductibles/coinsurance.

   Patients are responsible for verifying lab test coverage prior to testing. Some lab tests such as STD or hormone testing, lipid panels, and Vitamin D testing may not be covered by your insurance. Other tests may have a copay or charges towards your deductible or coinsurance. Many screening tests are not covered by Medicare. We do not verify any of this information. You are responsible for any lab fees not paid by your insurance.

   If you are undergoing surgery, it may be necessary, at Dr. Jukes' discretion, to use an assistant surgeon to safely complete your surgery. Any assistant surgeon fees not covered by your insurance will be your responsibility.

   If you are undergoing surgery, please note that Lisa M. Jukes, M.D. has a financial interest in Stonegate Surgery Center, LP and Arise Austin Medical Center.

   Patients without insurance coverage are eligible for a 30% discount off of our usual and customary billed fees. However, to receive this discount, payment must be made in full at the time of service.

2. **A 24 hour cancellation notice is required if you cannot keep your appointment**. There will be a fee of $100.00 applied to your account if we do not receive 24 hours' notice of a cancellation for an office-based appointment. 1 week's notice is required for the following in order to avoid the indicated fee: Pelvic Floor Rehabilitation - $150.00; LEEP, Hysteroscopy, Ablation, or Labiaplasty - $500.00; facility surgeries - $750.00. This fee must be paid in full before the missed appointment can be rescheduled. In addition, accumulating 3 "no-shows" without 24 hour cancellation notice for scheduled appointments will result in termination of the doctor-patient relationship.
3. For any balances on your account, you will receive an invoice requesting the payment that is due. **Please note that a finance charge of 3% will be accrued on any balance left unpaid for more than 45 days.** Failure to pay the outstanding balance will result in your account being sent to a collection agency. We will have no alternative but to terminate the doctor-patient relationship at this point. If your account is turned over to collections and you wish to reestablish care, you will be responsible for payment of the balance as well as a 40% charge to cover the costs of the collections agency. If there are unusual circumstances preventing you from paying your bill, please contact our financial coordinator Caroline at (512) 301 – 6767.
4. Please be aware that there is a $35.00 fee for the release of medical records to a patient. There is no fee for the release of medical records to another physician with written request from the patient. A minimum charge of $20.00 will be assessed for any paperwork to be completed by Dr. Jukes for your employer, school, attorney, etc. The exact fee will depend on the documentation required.
5. We do not accept the following insurance plans: Medicaid, Medicare, and Medicare Managed Care plans; Tricare Humana Military; Humana HMOs; BlueCross BlueShield HMOs; Aetna Advantage Plans (QHP). This is not an exhaustive list.
6. **On-time/paperwork completion policy:** We cannot consider your on time for your appointment until all necessary paperwork is completed in full. Paperwork is required for all new patients as well as yearly for established patients at their annual exams. If you do not have the required paperwork completed in full by the time of your appointment, it is possible that we may have to reschedule your appointment to a later time or different day if no later appointments are available. We reserve the right to charge you the appropriate cancellation fee if we are unable to see you for your appointment due to paperwork delays. You are always welcome to complete your paperwork ahead of time; all of your forms can be found on our website: lisamjukesmd.com.
7. **You may request a copy of this billing policy, an itemized statements of your account, or a written estimate of your out-of-pocket expenses for any service we provide at any time.**
8. Any questions or complaints regarding our billing policies can be directed to our financial coordinator Caroline at (512) 301 – 6767.

Please sign below to acknowledge this financial policy and agree to adhere to it.

Print Name:_____ **Signature:**_____ **Date:**_____