Gr d Rapids Men's Clinic, L.C.

Patient Profile

Name: _____ Date: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Ph: _____

Work Phone: _____ Cell Phone: _____

Age: _____ Date of Birth: _____ Preferred Contact # _____

Occupation: _____ Email: _____

Employer: _____ SSN: _____

Medical Questionnaire

(Please circle Yes or No)

Medical History

High Blood Pressure	Yes	No	Heart Attack	Yes	No
High Cholesterol	Yes	No	Blocked Artery	Yes	No
Diabetes	Yes	No	Coronary Heart Disease	Yes	No
Heart Disease	Yes	No	Stroke/TIA	Yes	No
Multiple Sclerosis	Yes	No	Parkinson's Disease	Yes	No
Epilepsy	Yes	No	Liver Disease	Yes	No
Hepatitis	Yes	No	Kidney Disease	Yes	No
Bowel Problems	Yes	No	Prostate Disease (BPH)	Yes	No
Prostate Cancer	Yes	No	Peyronie's Disease	Yes	No
Sexually Transmitted	Yes	No	HIV Infection/AIDS	Yes	No
Blood Transfusion	Yes	No	Major Depression	Yes	No
Tuberculosis	Yes	No	Bleeding Disorder	Yes	No
Sleep Apnea/Snoring	Yes	No			

Other _____

Current Medications (pills, injections, laxatives, sedatives, vitamins, others)

_____

Surgery

Heart	Yes	No	Blocked Artery	Yes	No
Prostate	Yes	No	Penis	Yes	No
Bowel	Yes	No	Bladder	Yes	No
Hernia	Yes	No	Vasectomy	Yes	No
Scrotum/Testes	Yes	No	Spine	Yes	No

Other _____

Previous Urology Problems

Kidneys	Yes	No	Penis	Yes	No
Bladder	Yes	No	Testicles	Yes	No
Prostate	Yes	No	Urine	Yes	No

Injuries

Head	Yes	No	Back	Yes	No
Pelvis	Yes	No	Penis	Yes	No

Other _____

History of Recreational Activities

Alcohol? No Yes How Often? _____

Smoking? No Yes How Much? _____

Recreational Drug: Marijuana, Cocaine, Meth, etc? No Yes How Often? _____

Family History

Diabetes	Yes	No	Premature Heart Attack	Yes	No
Cancer of the Prostate	Yes	No	High Blood Pressure	Yes	No

Social History: Marital Status: Single Married Divorced Separated Widowed

Physical Activity: Inactive Light Moderate Heavy

Allergies: Have you ever had an allergic reaction to any medications? Yes No
If yes, please provide details:

_____

_____

Main Complaint(s) Today:

			If yes, for what time period?
Difficulties in getting an erection	Yes	No	_____
Difficulties in maintaining an erection	Yes	No	_____
Early ejaculation	Yes	No	_____
Unable to ejaculate	Yes	No	_____
Painful ejaculations	Yes	No	_____

Please describe your main complaints:

_____

_____

Medications for Erectile Dysfunction:

	Never Used	When Started	When Stopped	Worked?	Side Effects?
Viagra					
Cialis					
Levitra					
Staxyn					
Caverject					
Muse					
Penile Pump					
Penis Ring					

Other _____

ADAM (Androgen Deficiency in the Aging Male) Questionnaire:

1	Have you had decreased libido (sex drive)?	Yes	No
2.	Have you experienced a lack of energy?	Yes	No
3.	Have you seen a decrease in strength / endurance?	Yes	No
4.	Have you experienced weight-gain?	Yes	No
5.	Have you noticed trouble sleeping?	Yes	No
6.	Are you sad / depressed?	Yes	No
7	Are your erections less strong?	Yes	No
8.	Have you seen an overall decline in health?	Yes	No
9.	Are you falling asleep after dinner?	Yes	No
10.	Are you doing less at work?	Yes	No

Please provide your current physicians:

	Name	Phone	Specialty	Last Visit
Family Physician				
Specialist				

Permission to share record with Physician and/or Specialist, if necessary? Yes No

Symptom Checklist for MEN

Use each of the following checklists to determine signs & symptoms of hormone imbalance and help you choose the appropriate profile.

Category 1: Basic Hormone Imbalance
Mark which of the following factors/symptoms are present and/or persist over time.

- ____ Burned out feeling
- ____ Hot flashes
- ____ Weight gain waist
- ____ Decreased libido
- ____ Decreased erections
- ____ Night sweats
- ____ Irritable
- ____ Erectile dysfunction
- ____ Prostate problems
- ____ Decreased mental sharpness
- ____ Insomnia
- ____ Increased urinary urge
- ____ Infertility problems
- ____ Oily skin
- ____ Apathy
- ____ Decreased urine flow
- ____ Decreased stamina
- ____ Sleep disturbances
- ____ Decreased muscle mass

Category 2: Adrenal Hormone Imbalance
Mark which of the following factors/symptoms are present and/or persist over time.

- ____ Aches and pains
- ____ Sleep disturbances
- ____ Chronic health problems
- ____ Stress
- ____ Depression
- ____ Lack of motivation
- ____ Prostate problems
- ____ Evening fatigue
- ____ Morning fatigue
- ____ Anxiety
- ____ Allergies
- ____ Weight gain waist
- ____ Decreased erections
- ____ Bone loss
- ____ Low blood sugar
- ____ Autoimmune disease
- ____ Fibromyalgia
- ____ Susceptibility to infections

Category 3: Thyroid Hormone Imbalance
Mark which of the following factors/symptoms are present and/or persist over time.

- ____ Low libido
- ____ Foggy thinking
- ____ Constipation
- ____ Elevated cholesterol
- ____ Depression
- ____ Infertility
- ____ Fatigue
- ____ Dry skin
- ____ Feeling cold
- ____ Headaches
- ____ Lack of motivation
- ____ Heart palpitations
- ____ Decreased erections
- ____ Sleep disturbances
- ____ Inability to lose weight
- ____ Brittle nails

Category 4: Cardiometabolic Risk
Mark which of the following factors/symptoms are present and/or persist over time.

- ____ History of smoking
- ____ High blood sugar
- ____ High blood pressure
- ____ Low physical activity
- ____ Weight gain
- ____ Sugar cravings
- ____ Fatigue
- ____ Elevated triglycerides
- ____ Heart disease or family history of heart disease
- ____ Diabetes or family history of diabetes
- ____ Waist size greater than 40 inches

If you checked symptoms in <u>all four categories</u>, the suggested test profiles are:
MINIMUM: Male Blood Profile II (Blood Spot)
PREFERRED: Comprehensive Male Profile I or II (Saliva/Blood Spot) and CardioMetabolic Profile (Blood Spot)

If you checked symptoms <u>ONLY in Category 1</u>, the suggested test profiles are:
MINIMUM: Male Blood Profile I (Blood Spot) or Female/Male Saliva Profile I (Saliva)
PREFERRED: Comprehensive Male Profile I or II (Saliva/Blood Spot)

If you checked symptoms <u>ONLY in Category 2</u>, the suggested test profiles are:
MINIMUM: Adrenal Stress Profile (Saliva)
PREFERRED: Comprehensive Male Profile I or II (Saliva/Blood Spot)

If you checked symptoms <u>ONLY in Category 3</u>, the suggested test profiles are:
MINIMUM: Essential Thyroid Profile (Blood Spot)
PREFERRED: Comprehensive Male Profile I or II (Saliva/Blood Spot); **OR** Female/Male Saliva Profile III plus Comprehensive Elements Thyroid Profile (Blood Spot/Dried Urine)

If you checked symptoms <u>ONLY in Category 4</u>, the suggested test profiles are:
MINIMUM: CardioMetabolic Profile (Blood Spot)
PREFERRED: CardioMetabolic Profile (Blood Spot) plus Female/Male Saliva Profile III (Saliva)

Grand Rapids Men's Clinic

161 OTTAWA NW SUITE 300
GRAND RAPIDS, MI 49503

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I UNDERSTAND THAT, Under the Health Insurance Portability & Accountability Act of 1998 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my heath information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Signature: _____ Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: _____ Initials: _____

Reason: _____

Grand Rapids Men's Clinic, P.C.
Informed Patient Consent

Please be informed:

You will be seen in a private examination room where you will be evaluated by a Michigan State Licensed Physician who will examine you, review your previous medical history, go over prescriptions your currently taking, and discuss treatment options that he suggests to you.

[ED/PE] The doctor may then perform some diagnostic tests. The doctor will locate the cavernosal artery in the penis and measure "passive" blood flow (when you are not sexually excited). The doctor will then apply a test of medication designed for your specific problem to the spongy tissue of the penis using an applicator. The test dose of medication contains a combination of commonly used vasodilators including Papaverine, Phentolamine, and Prostaglandin E1. This medication will dilate the arteries so that the "active" blood flow (as when you are sexually excited) through the penis can be measured. A partial or full erection lasting 40-60 minutes usually results from this application. Other rare effects of this procedure including some mild discomfort or light-headedness mostly due to nervousness, and also may cause some bruising where the injection site was. This reaction is generally normal. Rarely, this application may produce a full or partial erection lasting longer than two hours. Such prolonged erection is unusual and only occurs in those who are overly sensitive to the combination used. Should this possibility occur, you will be advised on what procedures to follow. These recommended procedures are safe and there is no additional cost to you if these procedures are needed. Rarely, long term and/or frequent use of this medication can cause scarring or from the micro-injection. All of these tests are required for GRMC's treating physicians to properly and effectively diagnose and treat your complaint. Both the Vascular Diagnostic test and this application are painless and safe. The physician will then prescribe a unique treatment designed to treat the cause for your Erectile Dysfunction on the very first visit.

I understand and have been advised that I <u>should not</u> receive a test dose if I have the following conditions: Sickle Cell Anemia or trait, Tumor of the bone marrow (multiple myeloma), penile implant, Fabry Disease, or Malaria. I also understand that its all up to the doctors discretion on whether I get a test dose as well. By signing below, I acknowledge that I am not presently suffering from any of the conditions. I further acknowledge that I have not used marijuana, or any recreational drugs such as cocaine, heroin, or ecstasy within the last 24 hours. **X_____(Initial Here)**

[Testosterone] I understand that initial blood test will be performed to establish my baseline hormone levels. I agree to comply with reasonable request for follow-up testing to assure proper monitoring of my hormone levels. I agree to report to the doctor any adverse reaction or problem that might be related to my hormone therapy. I understand that with testosterone replacement therapy, as with any other therapy, there may be side effects. Side effects of testosterone replacement therapy may include any or all of the following: mood changes, acne, hair loss, prostate enlargement, breast enlargement, or testicular shrinkage. I agree to report to the doctor any of these side effects. I understand that with hormone supplementation there are possible risks and complications if I do not comply with the recommended dosages. I understand that I will be in charge of administering the hormones and supplements prescribed to me. I will conform and comply with the recommended dosages and methods of administration. I understand that the role of GRMC is for the management of my hormone replacement only. I agree that I will be under the care of another health care provider for all other medical conditions. I agree that the physicians of GRMC will not take the place of my primary care physician in this regard. **X_____ (Initial Here)**

I understand and agree that Grand Rapids Men's Clinic P.C. Guarantees that in the event I fail to achieve an erection during the initial office visit, there will be no charge for the office visit. However, I acknowledge that GRMC P.C. cannot guarantee the success of any specific treatment plan, and in the event that I complete the office visit having achieved an erection, the cost of the office visit, and/or other treatment plan from the Grand Rapids Men's Clinic P.C., the treatment plan may include a maximum number of doses of medication, in addition to other goods and services, and should I fail or decline to request, properly self-administer or use all or some of those doses, the treatment plan, including any unused or unrequested doses and medication are not refundable and treatment plans expire two years from the date of purchase. Grand Rapids Men's Clinic's no-cost guarantee shall terminate at the time my initial office visit has ended.

X_____ (Initial Here)

I, (Patient) _____, fully understand the nature of the above tests, therapy and the possible side effects. I consent to a medical consultation fee of $99.00 upon completion of the visit, and I understand that the charges paid for any other plans, including medication(s) used or unused, which I may elect to purchase are final. I consent to treatment by my treating doctor should I experience and inopportune symptoms. I also understand that these services are considered elective treatment and are not covered by Medicare, and that any medications ordered by me are by law non-refundable and treatment plans expire after two years from the purchasing date that's located on the superbill.

I hereby authorize Grand Rapids Men's Clinic to maintain the records and medical charts for medical services provided to me, and I understand that these medical records and medical charts will not be released to any physician or anyone else without my prior written consent first being had and provided to Grand Rapids Men's Clinic P.C..

Signed this_____ day of _____, 20_____

Patient's Signature:_____

Doctor's Signature:_____

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D. Treatment	E. Reason Medicare May Not Pay:	F. Estimated Cost
Physician visit, prescribed medications, DME and/or tests to treat or diagnose erectile dysfunction.	**Medicare does not cover treatment for erectile dysfunction or any of the medication prescribed by this clinic.**	**The estimated cost is greater than $199.00. Final cost will vary based on treatment.**

WHAT YOU NEED TO DO NOW:

Read this notice, so you can make an informed decision about your care.
Ask us any questions that you may have after you finish reading.
Choose an option below about whether to receive the **D.** _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have; but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☑ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am not responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	**J. Date:**