Danielle E. Weiss, MD, FACP
Center for Hormonal Health and Well-Being
4407 Manchester Ave, Ste 101, Encinitas, CA 92024

Welcome to Our Practice,

I am looking forward to meeting you and helping you attain your best health possible!

Center for Hormonal Health and Well-Being is a personalized, proactive, patient-centered medical practice with a unique focus on Integrative Endocrinology. I pride myself on spending time truly listening to your concerns and needs. I rely on a team approach to develop a holistic plan to address these issues together. Please visit http://www.centerforhormonalhealth.com as I explain the philosophy behind our practice.

Please carefully read and fill out the following forms and fax/mail/email them back to us prior to your appointment. You may email the forms to staff@centerforhormonalhealth.com but this is not HIPPA (Health Insurance Portability and Accountability Act) compliant and privacy/security of your medical information cannot be assured.

To review prior records, complete various forms, letters, refill or change prescriptions outside of the office visit, and perform prior authorization for prescription drugs, requires significant time and effort on the part of the physician and staff. We accept many insurance plans but it is important that you review these costs not covered by your insurance. Please sign and return all forms, including the membership agreement form where you can decide between membership savings or non-membership pricing for services not covered by insurance. If you are unsure of which option to choose, please select non-member as you can always decide to become a member at a later time. If you will be seen more than two times per year or frequently require refills or change of prescriptions outside of the office visit, we recommend you choose to become a savings member. **If you are a Medicare beneficiary, please fill out, date and sign the Advance Beneficiary Notice of Noncoverage (ABN) and please choose either billing option 1 or 2.**

If there are recent labs, imaging studies or doctor notes that may be important, *please try to have these made available to us prior to, or at the time of, your appointment*. Send the medical record release form enclosed (pg. 5) to your referring doctor.

If you need to cancel/reschedule your appointment for any reason, *please give us 48 business hours notice.* **A full appointment fee may be charged for appointments not canceled within 48 business hours.** Arriving late to an appointment may be considered a missed appointment. Insurance does not cover this.

Patients using insurance plans ***will be required to have a credit card held on file*** to make payments for insurance benefits denied, deductibles not met, or inaccurate copay payments.

Once we have received an EOB (explanation of your benefits), your credit card will be charged for any of the above balances and a statement (aka EOB) from your insurance company will detail these charges. If there has been an overpayment on your co-pay or fee, your account will be refunded.

Please send a copy of the front and back of your insurance card to us and update us any time there is a change in your insurance - otherwise you will be billed as a cash pay patient. You are responsible for your deductible and co-payment. All co-pays are due upon check-in. If the deductible has been satisfied, we will bill your health plan. If the deductible has not been satisfied, payment is required at the time of service. Any balance carried to the next billing cycle will be subject to a monthly service charge. If it is necessary to assign your account to a collection agency and/or attorney, you will be responsible for these fees. Laboratory work charges are billed by the lab and are separate from our services. **Most HMO's and some PPO's require pre-authorization for services.** You are responsible for obtaining this. Patients are responsible to make payment within 60 days of claim submission if insurance processing is delayed or denied. If unsure of coverage, ***please contact your HMO/ PPO.*** **We do not accept United Healthcare or Medi-Cal: California Medicaid welfare program. If you have an EPO plan or Medicare Advantage plan, please contact your insurance plan to determine if they will cover our services.**

If Dr. Weiss has not seen you within one year of your last appointment, we will not be able to safely refill or prescribe your medication.

If you choose to communicate with us via email, please know that this form of communication is not HIPAA compliant unless it is done within PracticeFusion's patient health record. If you would like to sign up for the patient portal to communicate directly with Dr. Weiss, please request this service at the time of making your appointment.

The first visit and subsequent follow-up visit are critical for establishing the best care possible. Please know that if Dr. Weiss orders labs, imaging or any procedure, you will need to schedule a follow-up visit to discuss these results and further treatment considerations.

Lastly, we look forward to meeting you and helping serve your health related needs. Our goal is to build a true partnership with you. If you do not understand any aspect of your health care, please let us know. We want you to be completely satisfied with the care you receive in our office.

In Best Health,

Danielle Weiss, MD, FACP

I have read and understood all of the preceding and give my consent for medical treatment.
By typing your name, you are agreeing that this is the same as a written signature.

Patient Signature: _____ **Date:** _____

Patient Name (print): _____

Thank you for choosing ***Center for Hormonal Health & Well-Being.***

**** Please be sure to sign the OFFICE POLICY & FEES AGREEMENT ON PAGE 6 ****

**** Please be sure to include your CREDIT CARD INFORMATION on Page 3 ****

Please be sure to download and save this document before filling out the form. Then save again when form has been completed. After completing and saving, print and mail to address at the top of page 1 or fax to 760-465-2332. Note that each field has a a maximum character length.

Patient Face Sheet (please fill out completely)

Patient Legal Last Name:		**First Name:**		**MI:**			
Age:	Birthdate:	☐M ☐F	Marital Status:		SSN:		
Home Phone:		Cell Phone:		Work Phone:			
Home Address:		City:		St:	Zip:		
Mailing Address:		City: vvv		St:	Zip:		
E-mail Address:		Driver's Lic#:		St:			
Occupation:		Employer:					
Work Address:		City:		St:	Zip:		
Pharmacy Name/Address/Phone:							
Ok to leave medical information on voicemail? Yes No		If yes, list the preferred phone number (s):					
Spouse Name:		**DOB:**		**SSN:**			
Work Phone:		Employer:		Occupation:			
Emergency contact name (other than spouse):				Phone number (s):			
Patient referred by:							
Name of responsible party for bill (if different from patient):							
Relationship to patient:		Phone:					
Mailing Address (if different from patient):							
Name of Primary Insurance:				ID #:			
Group #:	Deductible $:		Co-pay or co-insurance amount:				
Subscriber on plan:		Birthdate:					
Relationship to patient:		**If Tricare, sponsor's SSN:**					
Which Tricare? ☐ Prime* ☐ Standard ☐ Retired							
Name of Secondary Insurance Company:				ID #:			
Group #:	Deductible $:		Co-pay or Co-insurance amount:				
Subscriber on plan:		DOB:		SSN:			

Prime requires referral from your primary care doctor. Without this, you will be considered a cash patient. Please list your name **exactly as it appears on your insurance card**.

Please bring your insurance card(s) with you to your visit. Without them, you will be considered a cash patient.

All the information on this form is true and accurate. **By typing your name, you are agreeing that this is the same as a written signature.**

Patient/Guardian Signature:	**Date:**
Credit Card No:	Zip code on billing address:

Exp.:	CVC:	Print Name Shown on Card:

Request for Release of Protected Health Information

AUTHORIZATION: I authorize the release of information pertaining to medical history, mental health, physical condition, services rendered or treatment as described below for:

Patient Name:		**Date of Birth:**	
SSN:	Phone Number:		
Release from (Record Holder):			
Street Address:	City:	St:	Zip:
Records may be released to: Center for Hormonal Health and Well-Being			
Street Address: 4407 Manchester Ave, Ste 101	City: Encinitas	St: CA	Zip: 92024
Phone Number: (760) 753-ENDO (3636)	Fax Number: (760) 465- 2332		
Dates of Service: From:		To:	
Location of Treatment: ☐ Inpatient	☐ Outpatient	☐ Emergency	

TYPE OF INFORMATION:
This authorization is limited to the following medical record type of information (put x next to all that apply):

	Discharge Summary		Progress Notes
	History/Physical Exam		Laboratory Tests
	Consultation Reports		X-ray Reports
	Operative/Procedure Reports		Photographs/Digital or other imaging
	Emergency Department Reports		Other (please specify):

SPECIAL CATEGORIES OF INFORMATION: You must specifically authorize the disclosure of the following types of information (check all that apply):

	HIV (human immunodeficiency virus) test results
	Psychiatric Records
	Alcohol and/or drug abuse treatment

USE OF INFORMATION: The requestor may use the medical records and type of information authorized only for the following purposes:

	Continuing Care		Personal		Other (please explain):
	Second Opinion		Insurance Claim		

All the information on this form is true and accurate. **By typing your name, you are agreeing that this is the same as a written signature.**

Printed Name:		**Date:**
Signature:		

If signed by other than patient, indicate relationship:

Witness:

Privacy Practice Acknowledgement & Release Medical Information Authorization

I hereby authorize **Center for Hormonal Health and Well-Being** to release any medical and/or billing information to my insurance company and/or referring or Consulting Health Care Providers. I understand the use of email is not a secure and private form of communication. I hereby acknowledge that I have been offered a copy of this office's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be available in the reception area, and that any amended notice of privacy practices will be available at each appointment.

By typing your name, you are agreeing that this is the same as a written signature.

Patient Signature:
Print Name:
Date:
If NOT signed by the patient, please sign below:
Print Name:
Indicate relationship:
Guardian or conservator: ☐Yes ☐No

Annual Membership and Office Policy Acknowledgement

We will continue to bill insurance for covered medical services whether or not you enroll as a member of Center for Hormonal Health and Well-Being.

Danielle Weiss, MD, FACP Membership Agreement and Agreement for Additional Services	
	Please see the separate Fees sheet located at http://CenterForHormonalHealth.com/Fees.pdf
After hours call (emergency only)	
Mailed copy of results (please note you can contact labcorp, quest and scripps directly to obtain access to your lab results by being set up with their individual patient portals)	
Prescription refills outside of a visit (please note that Dr. Weiss usually gives several month refills at a time to safely get you to your next follow up appointment. Please always ask for any refills that are needed at the time of your appointment to avoid needing refills outside of your visit)	
Urgent refills (less than 3 business days notice) or new prescription outside of an office visit	
Form completion: short/long	
Missed appointment without 48 business hrs notice	
Hourly rate for phone consultations, research, letters, review of outside records, dictated letters.	
Billing statement	
Credit card or check declined	
Insurance appeals/rebilling	
Patient Portal for 24/7 HIPAA compliant and secure email access to Dr. Weiss	
**We will continue to bill insurance for covered medical services whether you enroll as a member of Center for Hormonal Health and Well-Being or not.	

Please check one of the boxes below:

☐	I **choose to become** a Savings Member.	**$415 per year**
☐	I **wish to remain** a patient of Danielle Weiss MD,FACP, but choose not to save on the itemized services listed above.	

I understand the annual membership fee is nonrefundable and not prorated. I have provided my credit card information for service charges listed above as and when incurred. I agree to the information on these pages and the Membership Agreement and Office Policy Acknowledgement signed concurrently.

The undersigned has read, understands and agrees to the office policies on page 7, 8 and 9 that can also be found at http://www.centerforhormonalhealth.com/new_patient_forms.pdf. **By typing your name, you are agreeing that this is the same as a written signature and confirm that you have reviewed the separate Fees sheet.**

**Print Patient Name	Patient/Responsible Party Signature	Date
If signed by a party other than the patient, indicate the relationship by checking below (authorized representative must submit appropriate identification and necessary legal documents supporting authority).		
Parent or guardian of minor ☐	Guardian or conservator of patient ☐	

Office Policy Acknowledgement & Additional Services/Fees Information

Test Results: If you have not been notified of your results within one week, please contact the office. A follow-up appointment will be scheduled to discuss abnormal results regardless of membership status.

Prescriptions and Refills: Refills given outside of an office visit will be charged $25 and each additional refill will cost $10. Dr. Weiss usually gives several month refills at a time to safely get you to your next follow up appointment. Please always ask for any refills that are needed at the time of your appointment to avoid needing refills outside of your visit. If the refill is urgent (< 3 business days) or a new prescription, the fee is $50 with $10 charged for each additional refill. ***These fees are waived for members***. All medications require monitoring and regular follow-up visits. If you have not had an appointment with Dr. Weiss within 1 year you will need to make an appointment to safely take care of your prescription needs.

Patient Portal for 24/7 HIPAA compliant and secure email access to Dr. Weiss: You will also have access to any labs that Dr. Weiss orders for you from quest, labcorp or westpacific. You may also contact each of these labs directly to request a patient portal with each of these individual laboratory facilities once you have had labs drawn with them. The fee for access to the portal is $50 per year. ***This fee is waived for members.***

Appointment Cancellation/rescheduling: Non-members will be charged $75 for new patient appointments and $25 for follow-up appointments if less than 48 business hours notification given prior to cancelling or rescheduling. The first missed appointment is waived for members. Arriving late to an appointment may be considered a missed/cancelled appointment.

Hourly Rate: The non-member rate outside of an office visit is $350 per hour. Members have up to one-half hour included which can be applied to any service that is billed hourly such as review of outside records/test results ordered by other physicians. The rate for members after one-half hour is $250 per hour

Short form completion: $50 ***These fees are waived for members.***

Evening and Weekend Calls: I carry my office cell phone 24 hours a day, 7 days a week unless on vacation (a covering physician will be contacted). After hour calls are only in the case of an emergency. For non-members, the fee is $75 per call. ***These fees are waived for members for the first two occurrences.*** The member fee after that is $35 per call. Hourly rates may apply for complex coordination of care after hours.

Payment: Non-members and members agree to have their credit card charged at the time of service. You will be required to have an active credit card held on file to make payments for insurance benefits denied, deductibles not met, co-payments and other applicable services.

Maintain accurate insurance on file at each appointment. You understand that your insurance eligibility and benefits may change at any time. It is your responsibility to verify insurance coverage and benefits. If you do not have active insurance at the time of your appointment you agree to be charged cash pay rates. All co-payments and balances are due prior to your appointment. If your deductible has been satisfied, we will bill your health plan. If your deductible has not been satisfied, payment is required at the time of your service. Any balance carried to the next billing cycle will be subject to a monthly service charge. If it is necessary to assign your account to a collection agency, you will be responsible for these fees. Laboratory charges are billed by the lab and separate from our services. Most HMO's and some PPO's require pre-authorization for services. If this is not obtained or the HMPO/PPO refuses to cover within 60 days, the patient is responsible for services rendered. If unsure of coverage, contact your HMO/PPO. **We do not accept United Healthcare or Medi-Cal. If you have an EPO plan or Medicare Advantage plan, please contact your insurance plan to determine if they will cover our services.**

Patient Acknowledgment and Conditions of Participation: By signing below, you agree the benefits and services listed in the Membership Agreement and described above are not covered and are not reimbursable under your health insurance policy, health plan or government program in which you are enrolled. The membership fee and other fees payable under the Membership Agreement constitute payment for noncovered services only. You agree that you cannot and will not seek reimbursement from or under any health insurance policy, health plan or government program for the services provided under the Membership Agreement. In addition to the noncovered services provided under the Membership Agreement, I (Dr. Weiss) will also provide services that are covered and reimbursable under your health plan. In such cases, I will seek reimbursement from your health plan. I may also seek reimbursement from you as permitted under your health plan (e.g., deductibles, coinsurance or co-pays). By signing below, you agree any covered, reimbursable services are separate and distinct from the services provided under the Membership Agreement.

Term and Membership Fee: The Membership Agreement commences on the date of your signature on the Membership Agreement, shall continue for 1 calendar year and is not prorated or refundable.

Termination from Center for Hormonal Health and Well-Being: Our office values our relationship with you. Reasons for just cause termination include, but are not limited to: Repeated no-showing for scheduled appointments, not complying with recommended medical care, knowingly providing false or misleading information, being hostile or abusive to staff, not paying bills in a timely manner.

Our goal is to build a true partnership with you and we look forward to serving your health care needs. By typing your name below, you are agreeing that this is the same as a written signature.

Printed Patient Name **Patient/Responsible Party Signature** **Date**

If signed by a party other than the patient, indicate the relationship by checking below (authorized representative must submit appropriate identification and necessary legal documents supporting authority).

☐ **Parent or guardian of minor** ☐ **Guardian or conservator of patient**

Telephone Consumer Protection Act (TCPA) Opt In Consent form

Center for Hormonal Health and Well-Being and Practice Fusion utilize an automated patient notification system to quickly and efficiently notify patients of their upcoming appointment.

You must "opt" in to consent to receive automated communications on your mobile device.

You can revoke this consent at any time.

Please take a moment to fill out this consent form to receive these messages.

I, _____(printed patient name/guardian name), give Center for Hormonal Health and Well-Being and Practice Fusion permission to contact me via wireless telephone for automated phone calls, SMS text messages and/or emails. By signing, I certify that I am the owner of the wireless phone and/or email designated as the primary contact on the patient information form.

_____
Patient/Legal Guardian Signature

_____
Cell Phone number for the above

_____
Date

Center for Hormonal Health and Well-Being Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name:

Patient Date of Birth:

Information to be released: (ie. lab reports, progress note (s), radiology report, complete records, pathology report)

Release my protected health information to the following:
List route you would like information sent (ie. fax, email)

Name:

Address:

Phone number:

Fax number:

Email:

Reason for release:
When will this release expire?

Signature:

Today's Date:

FOR MEDICARE BENEFICIARIES ONLY: Please fill out if you have Medicare

A. Notifier: *Danielle E. Weiss, MD - Center for Hormonal Health and Well-Being*
4407 Manchester Ave, Ste. 101, Encinitas, CA 92024

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

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for ***D. CASH SERVICES*** 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. CASH SERVICES* below**:

D. Cash Services	**E. Reason** Medicare May Not Pay	**F. Estimated Cost** (Becoming a member will reduce some of these costs.) See previous membership form.
1. Copy Records	**Noncovered Services For Medicare Part B Plan**	
2. Review Records		**Please see the separate Fees sheet**
3. Prescription refills, outside of an office visit		**located at**
4. Urgent Refills, less than 3 business days notice		**http://CenterForHormonalHealth.com/ Fees.pdf**
5. Fill out form – short/long		
6. Phone visit to discuss test results and mail copy to you		
7. Phone calls and/or emails – during office hours – uncomplicated		
8. Phone call after hours (emergency only)		
9. Missed Appointments: Reschedule 48 business hours or less		
10. Statement Preparation		
11. Phone consults, research, letters, review outside records, dictated letters, coordination of care		
12. Returned Check or Credit Card return		
13. Insurance appeals or re-billing		
14. Patient Portal		
15. Practice Membership – Annual renewal		

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. CASH SERVICES** 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. CASH SERVICES** listed above. You may ask to be paid now, but I 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. CASH SERVICES** 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. CASH SERVICES** listed above. I understand with this choice I am **not** responsible for payment, and I **cannot appeal to see if Medicare would pay**. *(Selecting this option is not advisable if you wish to remain a patient as many of these services are not considered optional. We are merely informing you of the costs in advance should you incur any of these services.)*

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. **By typing your name, you are agreeing that this is the same as a written signature and confirm that you have reviewed the separate Fees sheet.**

I. Signature	**J. Date**

If signed by a party other than the patient, indicate the relationship by checking below (authorized representative must submit appropriate identification and necessary legal documents supporting authority).

☐ Parent or guardian of minor ☐ Guardian or conservator of patient

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850. Form CMS-R-131 (03/11) Form Approved OMB No. 0938-0566

Danielle E. Weiss, MD, FACP
Center for Hormonal Health and Well-Being

Patient Information for Medical Records

Date:	
Acct. No.:	

Confidential Record Information contained here will not be released unless you have authorized us to do so.

Last Name:		**First Name:**		**MI:**
Home Address:		City:	St:	Zip:
Age:	Birthdate:	Sex: ☐ M ☐ F	Marital Status:	SSN:
Home Phone:		Cell Phone:	Religion (optional):	Race (optional):
Occupation:		Employer:		
Person to notify in case of emergency:		Address:		Phone:
If different than above, please list family members or friends who can act as health advocate and their contact information				
Primary Care Physician		Address:		Phone:
Referring Physician		Address:		Phone:

Briefly describe your present medical symptoms, diagnosis and reason for your visit today:

Please list anything else you would like me to be aware of that is important for you to receive optimal and respectful care.

Family History			**If Living**		**If Deceased**	
	Sex		Age	Health	Age at Death	Cause
	M	**F**				
Father	☐	☐				
Mother	☐	☐				
Brothers/Sisters (check Sex)	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				
Husband/Wife	☐	☐				
Sons/Daughters (check Sex)						
	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				

Patient Name:
Patient Number:

Medications, Supplements, OTC (over-the-counter) non-prescription products, vitamins, minerals, nutritional supplements, homeopathic or naturopathic remedies, herbal preparations, Oriental/Chinese medicines, folk remedies: Please list the medications you are taking. Use additional sheet(s) if necessary.

MEDICATION OR SUPPLEMENT:	STRENGTH:	FREQUENCY:

Medication and food allergies: (If any allergy results in swelling around the mouth, shortness of breath, or hives please put anaphylaxis next to the medication.)

Operations (write in type and year):

Have you ever had a **transfusion**? If so, when?

Write in the names of any **diseases** you have had which required hospitalization**:**

Serious **illnesses** which you have had (not requiring hospitalization):

Serious **injuries or** accidents:

Has your weight changed in the past year? If so, by how much? **+ OR -**

What is your current weight? How tall are you?

Do you know any blood relative who has or had:

	Check	Relationship		Check	Relationship		Check	Relationship
☐	Stroke		☐	Heart attack		☐	Asthma	
☐	Cancer		☐	Stomach Ulcers		☐	Hay fever	
☐	High blood pressure		☐	Kidney Disease		☐	Bleeding tendency	
☐	Tuberculosis		☐	Goiter		☐	Insanity	
☐	Diabetes		☐	Epilepsy		☐	Arthritis	
☐	Leukemia		☐	Suicide		☐	Colitis	
☐	Rheumatic heart		☐	Migraine		☐	Nervous breakdown	
☐	Congenital heart							

Personal Habits (enter Y for Yes or N for No):

Do you regularly smoke?		Cigarettes	Pipe	Cigars	For how long?
Do you drink caffeinated beverages?		How many per day?			
Do you have difficulty falling asleep?		Do you awaken without apparent cause?			
Do you regularly drink alcohol?		How many ounces per day?			

List dietary restrictions; gluten, lactose, vegan, paleo, Atkins, etc.			
Previous diet programs (i.e., Weight Watchers)?			
Weight 5 years ago, 2 years ago, 1 year ago, six months ago?			
Religious or personal beliefs that influence health care (i.e., Jehovah's Witness)?			
Occupational history? Any radiation or chemical exposures?			
Travel history?			
What are you passionate about?			
	Y N		**Y N**
Do you frequently have severe headaches?		(If yes, answer the following):	
Do they cause visual trouble?		Do they occur on one side of the head?	
Do they feel like a tight hat band?		Do they awaken you at night from sleep?	
Do they hurt most in the back of the head/neck?		Does aspirin relieve them?	
Have you ever fainted?		Have you ever had a convulsion?	
Spells of dizziness?		Double vision?	
Spells of weakness of an arm or leg?		Pains in the ear?	
Ringing in ears?		Nosebleeds?	
Have you ever been treated for depression?			
Have you ever been treated for anxiety?			
Have you ever seen a psychologist/psychiatrist?			
Comments:			
Do you frequently experience any of the following:	Y N		
Bleeding gums?		Sore tongue?	
Trouble swallowing?		Nausea and/or vomiting?	
Hoarseness?			
Have you ever had shortness of breath?			
Doing your usual work?		Which causes you to cough?	
Climbing a flight of stairs?		Accompanied by sneezing?	
Which awakens you at night?		Have you ever coughed up blood?	
Do you have a chronic cough?		Do you cough up much sputum?	
Have you ever had chest pain or tightness in the chest?			
When exerting yourself?		Which radiates down the arm?	
When walking against a wind?		Which disappears if you rest?	
When walking up a hill?		Which occurs only at rest?	
After a heavy meal?		When walking fast?	
When upset or excited?		When walking in cold weather?	
If you have chest pain or tightness please explain:			
Have you ever had pain in the stomach which:			
Occurs 1-2 hours after a meal?		Occurs only at rest?	
Is brought on by eating fried or gassy foods?		Awakens you at night?	
Is relieved by antacid medications?		Is relieved with milk or eating?	
Occurs while eating or immediately after?		Do you have a loss of appetite	
Is relieved by a bowel movement?			

If you have had a change in bowel habit recently answer the following:	Y N	**When or since when?**
Crampy pain in the abdomen?		
Alternating diarrhea and constipation?		
Pain during or after bowel movement?		
Mucous in the stool?		
Blood in the stool?		
Ribbon-like stools?		
Require use of strong laxatives or enemas?		
Have you had:	**Y N**	**When or since when?**
Burning when urinating?		
Loss of control of bladder?		
Blood in the urine? Dark colored urine?		
Trouble starting to urinate?		
Trouble holding the urine?		
Getting up frequently at night?		
Passed a kidney stone?		
Have you recently had:	**Y N**	**When or since when?**
Pains in calves or legs when walking?		
Cramps in legs at night?		
Pain in the big toe?		
Varicose veins?		
Phlebitis or inflamed leg veins?		
Swelling in the ankles?		
To be answered by WOMEN only:	Y N	
Do you have regular monthly menstrual periods?		Age of first menstrual cycle or "period"
Have you ever had bleeding between periods?		When?
Do you have heavy bleeding with your periods?		When?
Do you feel bloated/ irritable before your period?		When?
Do you take/have you taken the birth control pill?		When?
How many children born alive?		How many stillbirths?
How many premature births?		How many miscarriages?
How many cesarean operations?		Age at time of 1st child birth?
Any complications of pregnancy (if Yes, explain)?		
Date of last menstrual period?		Are you in menopause?
Do you regularly have pap smears?		Age at time of menopause?
Date of last test?		Was menopause spontaneous?
Have you ever had discharge from the nipple?		Menopause due to hysterectomy?
Have you taken hormones?		
To be answered by MEN only: Have you ever had:	Y N	
Loss of sexual activity?		For how long?
Treatment for genitals?		
Discharge from penis?		
Hernia (rupture)?		
Prostate trouble?		

Do you wish any further information about Advance Directives? (a written statement of a person's wishes regarding medical treatment if unable to communicate them to a doctor) ☐ Yes (Click here) ☐ No

A. Notifier:

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

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: Due to COVID-19 Medicare and most commercial insurance is covering telehealth visits. This may change in the future. If Medicare or your commercial payer doesn't pay for items listed in table D. below, you may have to pay.

D.	E. Reason Insurance May Not Pay:	F. Estimated Cost
New patient (telehealth and/or in-person)	Not a covered benefit	$212.70
Follow-up patient (telehealth and/or in-person)	Not a covered benefit	$142.76
Appointment hold deposits (will be refunded if cancellations or changes are made with more than 48 business hours notice)	Not a covered benefit	New Patient Appts $75 Follow up Appts $25

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. telehealth service** listed above.

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

☐ **OPTION 1.** I want the **D. telehealth service** listed above. I understand that if Medicare or my commercial insurance doesn't pay, I am responsible for payment, but **I can appeal to Medicare or my commercial insurance.** If Medicare or the commercial insurance plan does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D. telehealth service** listed above, but do not bill Medicare or my commercial insurance. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare or my commercial insurance is not billed**.

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

H. Additional Information:

Signing below means that you have received and understand this notice and the disclaimer on Page 18.

I. Signature:	J. Date:

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Disclaimer:

I understand that I am registering for a TeleHealth appointment with Dr. Danielle Weiss at Center for Hormonal Health and Well-Being

I understand that TeleHealth technology will be used to connect me with Dr. Danielle Weiss. Telehealth appointments may be conducted by videoconferencing. I understand that this appointment will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider. I understand that the health care provider will be unable to complete a physical examination during this visit.

I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my healthcare provider or I can discontinue the TeleHealth appointment if it is felt that the videoconferencing connections are not adequate for the situation. I understand that I can discontinue the TeleHealth appointment at any time.

I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the appointment other than my healthcare provider to complete documentation and orders. The above-mentioned people will all maintain confidentiality of the information obtained.

I have had the alternatives to a TeleHealth appointment explained to me, and in choosing to participate in a TeleHealth appointment, I understand that some parts of the evaluation such as physical examination or on-site testing will be unavailable.

In an emergency situation, I understand that the responsibility of the TeleHealth specialist or provider may be to direct me to emergency medical services, such as the emergency room.

I understand that billing for the TeleHealth appointment will occur from 1) the primary care provider and 2) TeleHealth provider, and 3) as a facility fee from the site from which I am presented. Billing is at the discretion of the provider. Billing procedures will be explained to me.

I have read this document carefully, and understand the risks and benefits of the TeleHealth appointment and have had my questions regarding the procedure explained and I hereby consent to participate in a TeleHealth appointment visit under the terms described herein.