Driver's License

MMi Men's Medical Institute
TESTOSTERONE REPLACEMENT THERAPY

PATIENT REGISTRATION FORM

Date: _____

Chart Number: _____

PATIENT INFORMATION

How did you hear about / Who referred you to MMi? _____

Last Name_____First Name _____MI_____

Address_____City_____St_____Zip_____

Best # to Contact You: ( ) -_____- _____ E-mail Address _____

DOB _____/_____/_____ Height _____ Weight _____ SS # _____- _____ -_____

Marital Status (circle): *Single / Partnered / Married / Separated / Divorced / Widowed*

Employment Status: (circle) *Full-time / Part-time / Retired / Self-employed / Active Military / None*

What's the best form of contact? (circle) *E-mail / Phone* *Work Address Zip* _____

EMERGENCY CONTACT

Name_____ Relationship to Patient_____

Best # to Contact You: ( ) -_____- _____

Do you have an advance directive? ☐ Yes (If so, please provide us a copy) ☐ No

INSURANCE INFORMATION

PRIMARY INSURANCE_____

Address_____City_____St_____Zip_____

Insured ID # _____ Group #_____Phone ( ) -_____ - _____

Policy Holder Owner (if different than yourself) _____

Insured DOB_____ Patient Relationship to Policy Owner _____

NOTICE OF OUR PRIVACY PRACTICES

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information.

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY. Our practice is dedicated to maintaining the privacy of your individually identifiable health information (**IIHI**). In conducting our business, we will create records regarding you and your treatment and the services we provide for you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this Notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at this time. We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this Notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this Notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Men's Medical Institute
1062 Old Des Peres Road
St. Louis, MO 63131
314-394-1660

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS:

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. Any of the people who work for our practice – including, but not limited to, our doctors and nurses, or indirectly with any provider we refer you to – may use or disclose your IIHI in order to treat you, or to assist others in your treatment. Additionally, we may need to disclose your IIHI to others who may assist in your care, such as your spouse, children, or parents.
2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for TRT.
3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you receive from us, or to conduct cost management and business planning activities for our practice.
4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you or a family member who answers the phone (or to leave a recorded message) to remind you of an upcoming appointment.
5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.
7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to our office for care.
8. **Disclosures Required by Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES
The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:
- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. In general, we will require that the party that requests your records provide a records-release form, signed by you within the last 3 months.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:
- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organs and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a research that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research, and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the research only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research, and if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you; (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

Consent for Testosterone Replacement Therapy

Patient Name: _____

SOME THINGS YOU SHOULD KNOW ABOUT TESTOSTERONE REPLACEMENT THERAPY

It is important to understand that medicine is an inexact science. Although we will carry out your treatment carefully, results can vary in their degree of success. It is quite natural for a patient undergoing Testosterone Replacement Therapy to want to know that everything will turn out all right. Most of the time it will be fine; however, it is necessary to discuss potential risks.

It is very important for you to be aware of the potential risks, as well as the benefits, expected from the treatment when deciding on whether to begin Testosterone Replacement Therapy. You should also be aware of the alternatives to Testosterone Replacement Therapy, including not receiving the treatment.

It is important that you consider the information we have provided you. Be sure that you are doing what is right for you. If you are unsure, then perhaps you should take some time to weigh your options or consult another health care provider.

Please review the following pages, which discuss informed consent. Any questions that you may have should be brought to our attention. Your clinical provider will attempt to answer all of your questions to your satisfaction.

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

___1. This is my consent for Men's Medical Institute, including any physician or nurse who works with the company, to begin treatment for Testosterone Replacement Therapy

___2. It has been explained to me, and I fully understand, that occasionally there are complications with this treatment, including:

a) Acne
b) Breast enlargement
c) Mood swings
d) Extra fluid in the body. This can cause problems for patients who have heart, kidney or liver disease
e) Prostate enlargement, which may cause problems with urinating
f) Change in cholesterol levels, red blood cell levels, PSA levels, and liver function enzymes, and other hormone levels which will be monitored with periodic blood tests

___3. I understand that some studies have suggested an increased risk of stroke or heart attack in men initiating testosterone replacement therapy. I understand that this risk may be most significant in men over age 65 years or in younger men with underlying coronary artery disease/vascular disease.

___4. I understand that I will have periodic blood tests to monitor my blood levels and that this can be painful and leave bruises on the skin

___5. I understand there is no warranty or guarantee as to the result and that my condition may return or become worse

___6. I have had an opportunity to discuss with Men's Medical Institute and its medical practitioners my complete past medical and health history including any serious problems and/or injuries. All of my questions concerning the risks, benefits and alternatives have been answered. I am satisfied with the answers

___7. I understand that the physical exam by Men's Medical Institute does NOT replace a full physical exam by a personal physician

___8. I agree to have my personal physician perform a yearly full physical exam including a digital rectal exam, lipid profile, cholesterol levels and a comprehensive metabolic panel. If I do not have a personal physician Men's Medical Institute will assist in locating one for me

_____

Patient Date

_____

Physician Date

_____

Witness Date

MMi Men's Medical Institute
TESTOSTERONE REPLACEMENT THERAPY

Print the Patient Name	Date

MMi Men's Medical Institute
TESTOSTERONE REPLACEMENT THERAPY

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

_____	_____
Patient Name	Date
_____	_____
Men's Medical Institute Representative	Date

MMi

Men's Medical Institute

Testosterone Replacement Therapy

Patient Medical History Form

1. Are you in good health at the present time to the best of your knowledge? Yes No
   If no please provide explanation.

2. Are you under a doctor's care at the present time? Yes No
   If yes, for what?

3. Are you taking any medications at the present time? Yes No

Prescription or Over the Counter Medications, please list all:

Drug: Dosage

4. Do you have any allergies to any medications? Please list all:

5. History of High Blood Pressure? Yes No
6. History of Diabetes? First diagnosed at what age? Yes No
7. History of Heart Attack or Chest Pain or other heart condition? Yes No
8. History of Swelling Feet? Yes No
9. History of Sleep Apnea? Yes No
10. History of Thyroid disease? Yes No
11. History of Hormone problems or low testosterone levels? Yes No
    If yes, what and how was it treated?
12. History of BPH (Benign Prostatic Hypertrophy)or other prostate problems Yes No
13. Have you ever had trouble urinating? If yes describe: Yes No
14. History of Prostate or Breast Cancer ? Yes No
15. Family history of Prostate Cancer? Yes No
16. History of DVT or blood clots in legs or lungs? Yes No
17. History of Polycythemia?(Disease caused by your body making too many red blood cells)

    Yes No

18. History of low sperm count? Yes No
19. Are you planning to have more children? Yes No
20. Have you ever been on Testosterone Replacement Therapy before? Yes No
21. History of Liver problems? Yes No

Date of last annual physical exam:_____

Name of Primary Care Physician:_____

Date of last PSA:_____ Date of last prostate exam_____

22. Do you smoke? Yes No
23. Do you drink beer, wine or hard liquor? Yes No
    If yes, frequency_____. How many drinks_____.

Circle which best describes your exercise habits:

Sedentary (no exercise) Mild/Occasional/Regular vigorous exercise

Symptoms of Low Testosterone Levels	**Yes**	**No**
Difficulty concentrating		
Moodiness		
Depression		
Weight gain		
Decreasing sex drive		
Increasing fatigue		
Decreasing energy		
Daytime sleepiness		
Erectile dysfunction		

I have received or reviewed the Privacy Practice Notice for Men's Medical Institute, and understand the situations in which this practice may need to utilize or release my medical records. I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practice statement.

I understand periodic blood tests are necessary when receiving Testosterone Replacement Therapy.

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

Each patient is expected to have a full yearly physical including a Prostate exam with your Primary Care Provider.

Your signature constitutes your understanding of the above information.

Please sign and date this form: _____ date: _____