PATIENT REGISTRATION FORM

(Please complete all sections)

Last Name: _____ First Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: (C) _____ (H) _____

Email: _____ DOB: _____ Marital Status: _____

Sex Assigned at Birth: ☐ Male or ☐ Female SSN: _____

Emergency Contact: _____ Relationship: _____

Phone Number: (C) _____ (H) _____

INSURANCE INFORMATION

Insurance Company: _____

Name of Primary Insured: _____ Relationship: _____

Insured DOB: _____ Address: _____

Subscriber ID #: _____ Group #: _____

Claims Address: _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____

Name of Insured on Card: _____ Contact #: _____

Subscriber ID #: _____ Group #: _____

ASSIGNMENT AND RELEASE

I, the undersigned, hereby authorize and direct my insurance carrier(s) to pay directly to Amazing Meds all insurance benefits, if any, due to me under my plan(s). I further agree to pay the balance of the charges not paid by my insurance. Any Balance that is not paid within 45 days will also be my responsibility. I hereby authorize and release of any information necessary to secure payment of benefits. I also authorize the use of this signature on all insurance submissions. If the patient is a minor, I as the legal guardian give consent for treatment for this and future services rendered. I have received the Notice of Privacy Practices, and I have been provided an opportunity to review it.

Patient/Responsible Person Signature: _____ Date: _____

(please sign or type your full name)

MEDICAL HISTORY

Patient Name: _____ DOB: _____

Height: _____ Weight: _____ Allergies (please include reactions): _____

_____

_____

Medications *(prescription, over the counter, Vitamins, Herbs, etc.)*:

Drug Name	Dose	Drug Name	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Surgeries *(please list what and when)*:

_____

_____

_____

_____

Past Medical History and Review of Symptoms:

(Please check if you have had any problems with or are presently experiencing any of the following)

☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Heart Disease	☐ Colitis
☐ Chest Pain/Tightness	☐ Shortness of Breath	☐ Swollen Ankles	☐ Palpitations	☐ Anemia
☐ Lightheadedness	☐ Frequent Urination	☐ Rheumatic Fever	☐ Asthma	☐ Bronchitis
☐ Pneumonia	☐ Persistent Cough	☐ Tuberculosis	☐ Hay Fever	☐ Headache
☐ Thyroid Disease	☐ Indigestion	☐ Nausea	☐ Vomiting	☐ Arthritis
☐ Change in Bowel Habits	☐ Diarrhea	☐ Unexplained Weight Loss/Gain		☐ Hepatitis
☐ Gallbladder Disease	☐ Hemorrhoids	☐ Head or Neck Rotation	☐ Difficulty Urinating	☐ Anxiety
☐ Jaundice	☐ Kidney Disease	☐ Abdominal Discomfort	☐ Venereal Diseases	☐ Gout
☐ Constipation	☐ Low Back Problems	☐ Skin Diseases	☐ Kidney Stones	☐ Depression
☐ Impotence/Erectile Dysfunction	☐ Alcohol Abuse	☐ Drug Abuse	☐ Other: _____	

Male and Female Symptoms

(Please check if you are experiencing any of these symptoms or would like to improve in these areas)

☐ Concentration Difficulties	☐ Low Energy	☐ Loss of Confidence	☐ Increased Sense of Stress
☐ Decreased Muscle Strength	☐ Muscle/Body Aches	☐ Low Libido/Sex Drive	☐ Difficulty Sleeping
☐ Mood Swings	☐ Joint Pain	☐ Hot Flashes	☐ Thinning or Loss of Hair
☐ Decreased Motivation	☐ Memory Issues	☐ Seizures	☐ Night Sweats
☐ Cold Intolerance	☐ Heat Intolerance	☐ Excessive Thirst	☐ Decreased Skin Elasticity/Wrinkles
☐ Suffer from Facial or Body Acne/Skin Blemishes		☐ Decreased Sense of Well-Being/Depressed	

Gynecologic and Obstetric History

Age of onset of menses _____ Length of Periods _____(ds) Pregnancies _____ Births _____

Miscarriages _____ Prolonged/Abnormal Bleeding: ☐ Yes or ☐ No, if yes, _____

History of Abnormal Pap Smears: ☐ Yes or ☐ No, if yes, _____

Abnormal Discharge: ☐ Yes or ☐ No Incontinence: ☐ Yes or ☐ No

Pelvic Pain: ☐ Yes or ☐ No, if yes, _____

When was your last: Pap Smear _____ Mammogram _____ Breast Exam _____

Family History

(Please check all that apply and mark which family members)

☐ Heart Disease:	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Maternal Grandparent	☐ Paternal Grandparent
☐ Colon Cancer:	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Maternal Grandparent	☐ Paternal Grandparent
☐ Breast Cancer:	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Maternal Grandparent	☐ Paternal Grandparent
☐ Diabetes:	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Maternal Grandparent	☐ Paternal Grandparent
☐ Asthma:	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Maternal Grandparent	☐ Paternal Grandparent
☐ COPD:	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Maternal Grandparent	☐ Paternal Grandparent
☐ Stroke:	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Maternal Grandparent	☐ Paternal Grandparent
☐ HBP:	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Maternal Grandparent	☐ Paternal Grandparent

Personal History

(Please Mark Yes or No)

Do you smoke, use tobacco products/vape? ☐ Yes or ☐ No, if yes, how often _____

Do you drink alcohol? ☐ Yes or ☐ No, if yes, how many drinks per day/week _____

Do you exercise? ☐ Yes or ☐ No, if yes, how often _____

Are you sexually active? ☐ Yes or ☐ No, if yes, are you trying to conceive _____

Are you using birth control? ☐ Yes or ☐ No, if yes, what _____

Are you or have you tried diet methods? ☐ Yes or ☐ No, if yes, what kind(s) _____

When was your last: Physical Exam _____ Prostate Exam(men) _____ Cholesterol Check _____

What services are you interested in?

(Check all that apply)

☐ Bioidentical Hormone Replacement Therapy ☐ Peptide Therapy ☐ Hair Loss Treatment ☐ Aging Support

☐ Treating Menopause Symptoms ☐ Skin/Nail Health ☐ Nutrition/Weight Loss ☐ Injury Prevention

☐ Sexual Wellness ☐ Other: _____

What are the top three goals you would like to meet in seeking treatment?

1. _____

2. _____

3. _____

PATIENT INFORMED CONSENT

Please read the following and sign below; I have discussed the reasons for taking female/male hormones with my provider. I understand why they are prescribing them, as well as the risks associated with taking hormones that include but are not limited to: the possibility of an increased risk of breast or endometrial cancer, blood clotting, stroke, or heart attack. I understand that there are different medications. I understand that my provider will do everything they know to do to decrease and minimize the risks of HRT. I understand that there are no guarantees that these measures will be effective at preventing the negative side effects mentioned above, as well as others that we do not yet know about. I accept the risks and unknowns of taking hormone therapy and wish to have my provider prescribe them tome.

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party (Amazing Meds).

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization and that I may have the right to refuse to sign this authorization. I will receive a copy of this authorization after I have signed it. A copy of this authorization isas valid as the original.

Telehealth or telemedicine involves the use of the Internet to facilitate electronic communication to enable healthcare providers at different locations to share individual patient medical information for the purpose of treatment and improving patient care. Providers may include medical practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, treatment, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images or lab results
- Life two-way audio and/or video
- Output data from medical devise and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification, and Amazing Meds will implement measures to safeguard patient date against intentional or unintentional corruption.

By signing this form, I understand the following:

1. I understand that the laws to protect privacy and confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time (Depending on the patient's location, this may affect future care and treatment since Amazing Meds is located in Colorado Springs, Colorado).
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
4. I understand a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time.
5. I understand that I may expect anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

I have read and understand the information provided above, have discussed it with my provider or Amazing Meds team as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my care.

I hereby authorize Amazing Meds to use telemedicine in the course of my diagnosis and treatment.

Patient gives consent to telemedicine visit: **Today's Date:**

_____ _____

(please sign or type your full name to acknowledge)

A. Notifier: Amazing Meds
B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D. Labs/Visits/Medications/Peptides **below, you may have to pay.**

Medicare does not pay for everything, even some care that you or your healthcare provider have good reason to think you need it. We expect Medicare may not pay for the **D.** Labs/Visits Medications/Peptides Below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
xx Labs	Not Medically Necessary	$135-$400
xx Visits	Not Medically Necessary	$140-185
xx Medications/Peptides	Non Covered Service	$50-$3000

WHAT YOU NEED TO DO NOW:

- Read this notice, so that 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.** Labs/Visits/Medications/Peptides 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.** Labs/Visits/Medications/Peptide 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 copays or deductibles.

☐ **OPTION 2.** I want the **D.** Labs/Visits/Medications/Peptides 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.**Labs/Visits/Medications/Peptides 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 may ask to receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: _____ DOB: _____

1. I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits/labs/medication. This includes any medical service or visit, exam, physical, lab testing, x-ray, EKG, and any other diagnostic testing ordered by the physician or the physician staff.
2. I understand and agree it is my responsibility and not the responsibility of the Physician or Office to know if my insurance will pay for my medical service or visit, exam, lab testing, x-ray, EKG, and any other service or diagnostic testing ordered by the physician or the physician's staff.
3. I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network amounts, usual and customary limit or any other type of benefit limitation for the services I receive, and I agree to make full payment whenever required.Furthermore, I acknowledge that I may not be seen for additional services until any outstanding balance is paid in full.
4. I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand and agree to be financially responsible and make full payment.
5. I understand and agree it is my responsibility to know if my PCP (Primary Care Physician) choice has been processed by my insurance company or plan. If I have requested a PCP change that s not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.
6. I understand that if I need a copy of my medical records, a printing fee will be charged.
7. I understand that any forms to be filled out by the physicians will have a fee assessed.
8. I understand that I will be required to provide a valid form of payment, either check or credit card which will be run electronically.
9. I understand that any account balance that is 90 days past due will be sent to collections.
10. I understand that it is my responsibility to ensure that my insurance and contact information is always current and updated.
11. I understand and agree that Peptides are not covered by my insurance and will not be reimbursable by my insurance.

Signature: **Today's Date:**

_____ _____

(please sign or type your full name to acknowledge)

Responsible Party Name: _____

(Please print name of responsible party if different from the patient)

CREDIT CARD AUTHORIZATION FORM

Card Type: ☐ VISA ☐ MasterCard ☐ Discover ☐ AMEX

Name on Card: _____

Credit Card Number: _____ Expiration Date: _____ CVC:_____
(mm/yy)

Billing Address: _____

City: _____ State: _____ Zip Code: _____

By signing below, I acknowledge that all information listed above is as accurate as possible and I also agree to all terms and conditions listed above.

By signing this form, you give Amazing Meds permission to keep the above card information on file to authorize for charges towards treatment (including, but not limited to: lab work, provider visit fees, and for prescribed medication). We will obtain your verbal or written consent prior to authorizing your card for payment when applicable.

Signature: **Today's Date:**

_____ _____

(please sign or type your full name to acknowledge)

*** Amazing Meds reserves the right to have a NO RETURN and NO REFUND policy.**

**** All orders will be processed once the payment clears. Please allow 10 business days for all orders to be processed.**

Amazing Meds
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