HEALTH ADDITIONS, PLLC
Gregory W. Childrey, M.D.

PATIENT PROFILE- **PLEASE PRINT CLEARLY - PAGE 1**

Patient's Last Name	First	Middle	□Mrs. □ Ms. □ Mr. □ Miss	Marital Status: Single□ Mar□ Div□ Sep□ Wid□
May we contact you by email?		Email Address:		

Street Address:	City	State	Zip

Home Phone	Day Phone	Cell Phone

Occupation	Employer	Date of Birth	Social Security Number

Ethnicity: □ African American □ Asian □ Caucasian □ Hispanic □ Mediterranean □ Middle Eastern □ Other

Emergency Contact:	Phone Number	Relationship

Spouse/Partner Name: (if applicable)	Phone Number

Spouse Employer:	Address/Phone Number

How did you hear about us?

What are your expectations of Bio-Identical hormone treatments?

Check all that apply

□ Anxiety	□ Auto-Immune Disease	□ Cancer	□ Endocrine Disorder
□ Hepatitis	□ Prostate Surgery	□ Mood Swings	□ HTR
□ Thinning Hair	□ Blood Clots	□ Liver Disease	□ Aches/Pains
□ Palpitations	□ Hypertension	□ Shingles	□ Diabetes
□ Thyroid Disorder	□ Weight Gain	□ Erectile Dysfunction	□ Jaundice
□ High Cholesterol	□ Night Sweats	□ Blood Diseases	□ Dry Skin
□ Heart Disease	□ Vasectomy	□ Restless Leg Syndrome	□ Suffered Stroke
□ PMS	□ Renal Disease	□ Low Blood Pressure	
□ Smoker	□ Alcohol Drinker ________________________ Per Week?		

Height	Weight	Desired Weight	Are you presently dieting? Y / N	Which Diet?

Current Meds, Vitamins, or Herbal Remedies

Surgical History:

PATIENT PROFILE- PLEASE PRINT CLEARLY-PAGE 2

Patient's Last Name First

Primary Care Physician:
Address: Phone Number:

Are you allergic to any medications? Y/N	If yes, please list them:
Do you exercise regularly? Y/N	What exercise program do you follow?

How often do you work out?

What other activities do you do in your leisure time?

Do you play any sports? Y/N What Sports do you play?

Consent for Use and Disclosure of Information

By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I understand that I am responsible for payment **in full** on the day of my office visit. I further understand that Dr. Childrey's office will **not** file my insurance and that **this service is provided through Health Additions which is out-of-network for all insurance companies. I have been informed that most private insurance companies, Medicare, and Medicaid do not cover bio-identical hormone pellet therapy, and therefore, I will not receive reimbursement for this expense.**

I certify that the information I have read with regard to my insurance coverage is correct and authorize the release of any information, including medical information, to my insurance company (companies) if they request it in order for them to determine benefit coverage for this treatment.

Please print name:

The above information is true to the best of my knowledge:

PLEASE SIGN Date

PATIENT'S NAME: ________________________________Today's Date: _________

PAST MEDICAL HISTORY:

Hypertension, Diabetes Mellitus Type 1or 2, Hyperlipidemia, Hypothyroidism,
Chronic Fatigue Sx, Infertility, Breast Cancer, Gynecomastia, Heart Disease,
Asthma/COPD, Anemia, DVT/PE
OTHER:____
____

PAST SURGICAL HISTORY:

Vasectomy Cholecystectomy Appendectomy
OTHER: ____
____
____

LAST PSA DATE: ______________ Results: Normal / Abnormal

Birth Control Method: None, Condom, Withdrawal, Vasectomy, Abstinence

FAMILY HISTORY:
Breast Cancer, Colon Cancer, Heart Disease, Lung Disease,
Prostate Cancer, Diabetes Mellitus, Hypertension, Stroke, Blood Clots
Other: ____
____
____

SOCIAL HISTORY:
Tobacco: Yes/ No Often? ________________Years_________ QUIT? ___________
Alcohol: Yes/No How Much? ____
Illicit Drug Use: Yes/No ____

Use of hormone supplements (gels, creams, pills, injections):
____
____

Patient's Physician: ____
____

Okay to send Dear Doctor Letter? Yes______ No______

MALE REVIEW OF SYMPTOMS

Name: ________________________________ Date: _________

SYMPTOM	NONE	OCCASIONAL	MODERATE	SEVERE
Hot Flashes				
Fatigue				
Night Sweats				
Low Libido				
Insomnia				
Irritable				
Mood Swings				
Weight Gain				
Depression				
Anxiety				
Difficulty Losing Weight				
Poor Exercise Tolerance				
Cold Body Temp				
Cold Hands & Feet				
Hair Loss				
Joint Pain				
Loss of Muscle Mass				
Visual Changes				
Panic Attacks				
Erectile Dysfunction				
Memory Lapses				
Bone Loss				
Water Retention				
Dry Skin				
Urine Incontinence				
Headaches				
Tearful				
Thinning Skin				
Foggy Thinking				
Increased Facial Hair				
Oily Skin				
Allergies				
Acne				
Heart Disease				
Decreased Concentration				
Insulin Resistance				
Swelling/Puffy Eyes				
Sugar Craving				
High Blood Sugar				

HEALTH ADDITIONS, PLLC

GREGORY W. CHILDREY, M.D.

PATIENT CONSENT TO LEAVE DETAILED MESSAGE/INFORMATION

Dear Patient

Gregory W. Childrey, M.D. requires our staff to obtain prior authorization to leave a detailed voice mail/messages for the patient. This policy is to protect the patient and also to protect our staff from violating the patient's confidentiality. If we do not have a signed consent form on file, the staff may leave only their name and a phone number on an answering machine asking you to call them back.

By completing the consent below, you hereby authorize the staff to call and leave their name, the doctor's name, and additional information on an answering machine or with a specific individual. Unless notified in writing, this consent will remain in effect permanently.

I give my consent to Dr.Childrey and or staff to leave a message regarding treatment, test results and other necessary information.

1) On the answering machine at home at this number:_______________

2) On voice mail at work at this number: ___________________________

3) On my cell phone voice mail at this number______________________

____

Patient's Signature Date

____Please print patient's name

I DO NOT Consent to any messages being left on an answering machine other than caller's name and phone number:

____

Patient's Signature Date

____Please print patient's name

HEALTH ADDITIONS, PLLC
Gregory W. Childrey, M.D.

INSURANCE DISCLAIMER FOR BIO-IDENTICAL HORMONE PELLET THERAPY (BHRT) CONSULTATION

- Our research has shown that **Medicare, Medicaid, and most commercial insurance companies DO NOT** pay for bio-identical hormone replacement therapy (Testosterone & Estradiol pellets) because they are considered experimental and investigational.

- ***You are responsible for payment of the office consultation fee in the amount of $95.00 payable at the time the service is rendered.**

- Our office will **NOT** send anything to **Medicare, Medicaid, or any private insurances pertaining to this service.**

- Dr. Childrey does bio-identical hormone replacement therapy (BHRT) through his business **Health Additions** and is **NOT** contracted with any insurance carriers**. Therefore, he is out-of-network with all plans for any service provided through Health Additions.**

I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT AT THE TIME OF THE CONSULTATION AND THAT MEDICARE, MEDICAID AND OTHER INSURANCES DO NOT COVER THIS TYPE OF SERVICE. I ALSO UNDERSTAND THAT HEALTH ADDITIONS IS OUT-OF-NETWORK WITH MY INSURANCE AND THEY WILL NOT FILE ANY CLAIMS ON MY BEHALF. I FURTHER UNDERSTAND THAT BHRT IS COMPLETELY ELECTIVE AND THAT NO GUARANTEES HAVE BEEN MADE TO ME REGARDING THE OUTCOMES OF THIS TYPE THERAPY. BY SIGNING THIS FORM, I AM ACKNOWLEGING THAT I HAVE BEEN INFORMED OF MY FINANCIAL OBLIGATION, AND I CONSENT TO HAVE THE SERVICE.

Signature ______________________________________ Date__________

***We reserve the right to change our consultation fee. If you have any questions, please contact our business office prior to your consultation.**

HEALTH ADDITIONS, PLLC
Gregory W. Childrey, M.D.

INSURANCE DISCLAIMER FOR BIO-IDENTICAL HORMONE PELLET THERAPY (BHRT)

- Our research has shown that **Medicare, Medicaid, and most commercial insurance companies** **DO NOT** pay for bio-identical hormone replacement therapy (Testosterone & Estradiol pellets) because they are considered experimental and investigational.

- **YOU are responsible for payment in full at the time the pellets are implanted.** The cost is as follows:

  ***Pellet insertion fee for women $ 295.00 - $325.00**
  ***Pellet insertion fee for men $595.00 - $650.00**
  ***Iodine supplement fee $ 30.00**

- Our office will **NOT** send anything to Medicare, Medicaid, or any private insurances pertaining to this service.

- Dr. Childrey does bio-identical hormone replacement therapy (BHRT) through his business **Health Additions** and is **NOT** contracted with any insurance carriers**. Therefore, he is out-of-network with all plans for any service provided through Health Additions.**

I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT AT THE TIME PELLETS ARE IMPLANTED AND THAT MY INSURANCE DOES NOT COVER THIS TYPE OF SERVICE. I ALSO UNDERSTAND THAT HEALTH ADDITIONS IS OUT-OF-NETWORK WITH MY INSURANCE AND THEY WILL NOT FILE ANY CLAIMS ON MY BEHALF. I FURTHER UNDERSTAND THAT BHRT IS COMPLETELY ELECTIVE AND THAT NO GUARANTEES HAVE BEEN MADE TO ME REGARDING THE OUTCOMES OF THIS TYPE THERAPY. BY SIGNING THIS FORM, I AM ACKNOWLEGING THAT I AM FREELY ELECTING TO TRY BHRT AND AGREE TO PAY THE ABOVE FEES.

Signature ____ Date__________

***We reserve the right to change our fees. If you have any questions, please check with our business office prior to insertion.**

HEALTH ADDITIONS, PLLC

Gregory W. Childrey, M.D.

MALE TESTOSTERONE PELLET INSERTION ACKNOWLEDGEMENT FORM

Although this therapy has been approved for human use, there are few doctors who currently administer Testosterone pellets in the United States. I realize that this is not the usual and customary means of prescribing testosterone. I realize that the advantages of testosterone may include:

A) Behavioral changes including decreasing depression, decreasing anxiety, and irritability, increasing energy and motivation, stabilizing mood, allowing one to cope better, improving one's self image, and enhancing one's stamina.
B) Improvement in one's cognitive functions (no longer operating "in a fog"), improving short term memory and allowing one to stay focused on a task.
C) Physical effects such as decreasing total body fat, increasing lean body mass, and increasing bone density and muscle mass.
D) Sexual benefits such as increased libido, increasing early morning erections, increased firmness and duration of erections.

I realize there are potential concerns with testosterone therapy that may include the possibility of enhancing current prostate cancer to grow more rapidly. Therefore, for this reason, a rectal exam and prostate specific antigen blood test is to be done before starting testosterone and must be done each year thereafter.

The second concern regarding testosterone therapy is that it may increase one's hemoglobin and hematocrit - or "thicken one's blood". This can be reversed through donating blood periodically. This problem can be diagnosed with a blood test. Thus, a complete blood count should be done at least annually.

The final concern, especially in younger men, is that testosterone administration may suppress the development of sperm. The sperm count could dramatically reduce while a person is on testosterone therapy. However, this appears to be a reversible process in which the sperm count is restored once the testosterone is discontinued. We encourage any man who is concerned with his fertility in the future to have semen analysis prior to initiation of testosterone therapy. Testosterone administration is **NOT TO BE USED** as a form of male contraception.

My signature certifies I have read and agree to the above. I have been encouraged to ask any questions regarding testosterone pellets. My questions have been answered to my satisfaction.

____

Patient's Signature Date

____

Patient's Printed Name