-NexGen Health and Wellness / 7424 Hwy 64, Suite 118 / Bartlett, TN 38133
Ph: (901)-244-6631 F: (901)-244-6573
www.nexgenhealthandwellness.com

PATIENT INFORMATION RECORD

Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth: ____ / ____ / ____ SEX: Male: _____ Female: _____ Marital Status: **M W D S**

Address: _____City: _____ State: _____ Zip: _____

SSN:_____ Primary Phone: _____
Cell Phone: _____

Email address: _____ Referred by:

Walk-in, Family/friend, website, social media, other: _____

Preferred Pharmacy: _____ Phone: _____

Occupation: _____ Employer: _____

Preferred Method of Communication: Home Work Cell Other: _____

In case of Emergency, contact: Last Name: _____ First Name: _____

Emer. Contact Phone# (_____) _____-_____ Relationship: _____

INSURANCE INFORMATION

Primary Insurance Name: _____ Policy Holder: Last_____ First _____ MI __

Insurance ID#: _____ Group#:_____ Policy Holder DOB: _____

Secondary Insurance Name: _____ Policy Holder: Last_____ First _____ MI __

Insurance ID#: _____ Group#:_____ Policy Holder DOB: _____

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician and agree to be financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

Signature (patient or, if minor Signature of guardian)	**Date**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize NexGen Health and Wellness and its employees, agents or associated healthcare practitioners to disclose my protected health information to the following individuals:

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

I understand that:

- Once this facility discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable to federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524). Furthermore, my records are protected and cannot be disclosed without written permission.

Signature	**Date**

ADULT REVIEW OF SYSTEMS

Patient Name: _____ **Chart**: _____

1. **Constitutional Symptoms**

Fever	No	Yes
Chills	No	Yes
Unexplained change in weight	No	Yes

2. **Cardiovascular**

Chest pain	No	Yes
Irregular heartbeats	No	Yes
Leg Swelling	No	Yes

3. **Respiratory**

Shortness of breath on exertion	No	Yes
Cough	No	Yes
TB exposure	No	Yes

4. **Gastrointestinal**

Nausea	No	Yes
Vomiting	No	Yes
Constipation	No	Yes
Diarrhea	No	Yes
Abdominal Pain	No	Yes

5. **Endocrine**

Breast Enlargement	No	Yes
Always Thirsty	No	Yes
Heat/Cold Intolerance	No	Yes

6. **Musculoskeletal**

Bone Pain	No	Yes
Back pain	No	Yes
Muscle Pain	No	Yes

7. **Neurological**

Tingling or numbness	No	Yes
Muscle weakness	No	Yes

8. **Skin**

Do you currently have a rash?	No	Yes

9. **Genitourinary**

Do you urinate at night? #_____	No	Yes
Urgent need to urinate	No	Yes
Slow to start stream	No	Yes
Painful urination	No	Yes
Burning during urination	No	Yes
Unable to urinate	No	Yes
Involuntary loss of urine	No	Yes
Dribbling after urination	No	Yes
Visible blood in urine	No	Yes

❑ **N/A** ****Male Only**: Symptoms of Low T**

Difficulty concentrating	No	Yes
Grumpy Mood	No	Yes
Lack of motivation/interest in activities	No	Yes
Weight gain, especially in abdomen	No	Yes
Daytime sleepiness	No	Yes
Increase in general fatigue	No	Yes
Poor sleep habits-insomnia	No	Yes
Decrease muscle strength	No	Yes
Decrease in sexual interest	No	Yes
Decrease in erections	No	Yes
Difficulty obtaining an erection	No	Yes
Difficulty keeping an erection	No	Yes
Pain during intercourse	No	Yes

10. **Psychiatric**

Anxiety	No	Yes
Depression	No	Yes
Difficulty sleeping	No	Yes

11. **Hematologic/Lymphatic**

Easy Bleeding	No	Yes
Bruise easily	No	Yes

12. **Allergic-Immunologic**

Allergy resulting in rash	No	Yes
Allergy causing difficulty breathing	No	Yes

Medical History Sheet

Patient Name: _____ **Chart**: _____

Height: _____ **Weight:** _____

Medical History: (please mark all you have ever been treated for or are currently being treated)

❑ **No Medical History**

General
- ❑ ADD/ADHD
- ❑ Anemia
- ❑ Bleeding Disorder
- ❑ Glaucoma
- ❑ MRSA
- ❑ Systemic Lupus Erythematosus
- ❑ Transplant Recipient, Organ:_____

Cardiovascular
- ❑ Atrial Fibrillation
- ❑ Blood Transfusion, Date: _____
- ❑ Chest Pain
- ❑ Congestive Heart Failure (CHF)
- ❑ Coronary Artery Disease (CAD)
- ❑ Clot in Leg or Lung
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Heart Valve Disorder, Type: _____
- ❑ High Blood Pressure (HTN)
- ❑ High Cholesterol

Endocrine/Metabolic
- ❑ Diabetes, Type I or II
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Low Testosterone

Respiratory
- ❑ Asthma
- ❑ COPD
- ❑ Pneumonia
- ❑ Sinus Conditions
- ❑ Sleep Apnea
  - ❑ Use CPAP

Gastrointestinal
- ❑ Acid Reflux/GERD
- ❑ Crohn's Disease
- ❑ Hepatitis
- ❑ Irritable Bowel Syndrome (IBS)
- ❑ Stomach Ulcer
- ❑ Ulcerative Colitis

Genitourinary
- ❑ Chronic Kidney Disease
- ❑ Genital Herpes
- ❑ Genital Warts
- ❑ Interstitial Cystitis
- ❑ Kidney Stones
- ❑ Renal Failure
- ❑ STD:_____
- ❑ Urinary Tract Infections

Men's Health
- ❑ BPH
- ❑ Erectile Dysfunction
- ❑ Prostatitis
- ❑ Previous Testosterone USE: _____

Women's Health
- ❑ Menopause
- ❑ PCOS

Musculoskeletal
- ❑ Arthritis
- ❑ Artificial Joints
- ❑ Chronic Back Pain
- ❑ Fibromyalgia
- ❑ Gout
- ❑ Neuropathy

Neuro/Psych
- ❑ Anxiety / Depression
- ❑ Headaches/Migraines
- ❑ Insomnia
- ❑ Multiple Sclerosis
- ❑ Psychiatric Disorders: _____
- ❑ Seizures: _____
- ❑ Stroke/TIA

Cancer
- ❑ Bladder
- ❑ Colon/Rectal
- ❑ Female, Type:_____
- ❑ Kidney
- ❑ Lung
- ❑ Prostate
- ❑ Other: _____

Other Medical History: _____

_____

Medical History Sheet

Patient Name: _____ **Chart**: _____

Surgical History: (please list ALLsurgeries you have ever had) *if additional space needed, please ask.

Surgery	Date

Social History: (circle or fill in appropriate response)

Current Alcohol Consumption: No Yes _____ drinks per week
History of Alcohol Abuse: No Yes _____ days/months/years sober

Current Tobacco Use: No Yes cigarettes/cigars **_____packs per day** **_____cigars per day**
History of Tobacco Use: No Yes Age start? _____ **Age stop? _____**
Smokeless Tobacco Use: No Yes # Cans of Dip per day _____

Recreational Drug Use:
____None ____Current, name substance(s)_____

Daily Fluid Intake: _____ 8 oz. cups of coffee per day _____ 8 oz glasses of water per day
_____ 8 oz. glasses of tea per day _____ 8 oz. glasses of milk per day

Activities/Exercise: ___ None ___ Mild Exercise ___ Occasional vigorous exercise ___ Vigorous 6x/week

❑ N/A **Male Health History**:
Unsure: ____ Date of Last PSA: _____ Date of Last Prostate Exam: _____ Normal ____ Abnormal ____

Family History: (please list type of cancer) *if additional space needed, please ask

Condition	*Relative: M, F, Sister, Brother, MGM, MGF, PGM, PGF*	*Living*	*Age passed*
Arthritis			
Cancer: (Type)_____			
Diabetes			
Heart Attack			
Heart Disease			
High Blood Pressure			
High Cholesterol			
Kidney Failure			
Stroke			
Thyroid Disorder			
Other:			

Patient Medication List

Patient Name: _____ **Chart**: _____

Date: _____

Local Preferred Pharmacy: _____ Pharmacy Phone: _____

(Please include Prescription, Vitamins, and Over-the-counter Medications)

Medication	Dose	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Allergies

(Please list all known allergies, reactions and cause)

_____ **No Known Drug Allergies (X or initials)**

Drug	Type of Reaction (Mild, Moderate, Severe)

Patient Name: _____ **Chart:**_____

NexGen Health and Wellness

Testosterone Consent Form & Terms of Acceptance

At the NexGen Health and Wellness, our goal is to help treat hypogonadism (low testosterone) and restore your testosterone to an optimal level, as well as improve your overall quality of life. The American Academy of Family Physicians has examined the effectiveness & safety of testosterone replacement therapy (TRT) and found that there is no compelling evidence of major side effects of properly administered TRT. Side effects can be controlled and may include, but are not limited to:

- **Injection Site Reaction**: Localized irritation, swelling, warmth or redness of surrounding skin.
- **Fluid Retention**: Fluid accumulation may be observed, especially in older men. Symptoms may include leg or ankle swelling, worsening of congestive heart failure, or high blood pressure.
- **Elevation in Red Blood Cells/Hemoglobin/Hematocrit (not as common)**: TRT may cause an increase in red blood cell concentration, hemoglobin and/or hematocrit levels, which may increase cardiovascular and clotting risk. This may require therapeutic phlebotomy or blood donation.
- **Breast Tissue Enlargement**: This is the result of testosterone converting into estrogen and may require dosage adjustments and/or medication to prevent conversion to estrogen.
- **Prostate Enlargement**: From conversion of testosterone to DHT. No current study has linked TRT to increased incidence of prostate cancer.
- **Possible Changes in Lipid & Cholesterol Levels**
- **Acne and/or Oily Skin**
- **Testicular Atrophy**: From decreased LH & FSH signal from pituitary.
- **Decreased Sperm Counts**: From decreased FSH signal from pituitary.

_____ (patient initial) All of the above conditions have been fully disclosed & explained by my NexGen Health and Wellness Provider.

_____ (patient initial) I have had the opportunity to discuss in detail my health history with my NexGen Health and Wellness Provider and all my questions were answered to my satisfaction.

_____ (patient initial) I consent to have NexGen Health and Wellness, including all providers or MA's that work for the company, to begin Testosterone Replacement Therapy (TRT).

_____ (patient initial) I understand that NexGen Health and Wellness recommends an annual physical examination.

_____ (patient initial) I understand that I will periodic blood tests performed in order to monitor my levels.

_____ (patient initial) I understand that there is no guarantee of my results once beginning and during treatment, and my condition may return upon discontinuation of treatment.

_____ Print Name

_____ Signature

_____/_____/_____ Date

Witness _____

Date_____

Patient Name: _____ **Chart**: _____

NexGen Health and Wellness ----HIPAA – Notice of Privacy Practices

NexGen Health and Wellness is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Summary of Rights and Obligations Concerning Health Information.
NexGen Health and Wellness is committed to preserving the privacy and confidentiality of your health information, which is required both by federal and state law. We are required by law to provide you with this notice of our legal duties, your rights, and our privacy practices, with respect to using and disclosing your health information that is created or retained by NexGen Health and Wellness. Each time you visit us, we make a record of your visit. Typically, this record contains your symptoms, examination and test results, our assessment of your condition, a record of your treatment interventions, and a plan for future care or treatment. We have an ethical and legal obligation to protect the privacy of your health information, and we will only use or disclose this information in limited circumstances. In general, we may use and disclose your health information to:

- ✓ plan your care and treatment;
- ✓ provide treatment by us or others;
- ✓ communicate with other providers such as referring physicians;
- ✓ receive payment from you, your health plan, or your health insurer;
- ✓ make quality assessments and work to improve the care we render and the outcomes we achieve, known as health care operations;
- ✓ make you aware of services and treatments that may be of interest to you; and
- ✓ comply with state and federal laws that require us to disclose your health information.

We may also use or disclose your health information where you have authorized us to do so.

You have the right to:
- ❖ ensure the accuracy of your health record;
- ❖ request confidential communications between you and your therapist and request limits on the use and disclosure of your health information; and
- ❖ request an accounting of certain uses and disclosures of health information we have made about you.

We are required to:
- ❖ maintain the privacy of your health information;
- ❖ provide you with notice, such as this Notice of Privacy Practices, as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- ❖ abide by the terms of our most current Notice of Privacy Practices;
- ❖ notify you if we are unable to agree to a requested restriction; and
- ❖ accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

Disclosure of Your Health Care Information:

We may disclose your healthcare information as necessary to comply with State Workers Compensation laws, Public Health Authorities, Emergency Situations, Judicial & Administrative Proceedings, Law Enforcement, Medical Examiners, Researcher that has been approved by an Institutional Review Board, when necessary to prevent a health or safety issue, to military or national security and government benefit purposes, for company approved marketing purposes, showing gratitude for referrals, and change of ownership. I understand and have been provided with a Notices of Privacy Practices, which provides a description of the information uses and disclosures.

I understand and had the right to review this notice prior to signing the consent, the right to object the use of my health information for directory purposes and the right to request restriction as to how my health information may be used or disclosed to carry our treatment, payment or healthcare operations.

_____ _____ _____/_____/_____

Print Name **Signature** **Date**

Revised 10/30/2019

Patient Name: _____ **Chart**: _____

Financial Agreement

I will pay in full for services at the time of my appointment unless I have insurance coverage that requires another arrangement, or I make a different agreement with my provider.

Payment for Services:

You are ultimately responsible for payment of services if your insurance carrier does not pay for any reason. IT IS THE RESPONSIBILITY OF THE PATIENT OR THEIR RESPONSIBLE PARTY/REPRESENTATIVE TO KNOW THEIR INSURANCE COVERAGE. Please present your insurance card at each visit. Insurance companies deny claims that are not submitted within 90 days of the date of service. If you do not submit your current insurance to the office at the time of your visit, you may be responsible for denied claims. We attempt to verify coverage before your visit with the information you provide. Verification of coverage does not guarantee the insurance company will pay for your visit. Insurance policies exclude some non-covered services; however, this does not mean services or tests are not necessary. It means the policy you have does not cover certain necessary services. Please keep in mind your insurance policy is a contract between you and the insurance company. The physician has no control over which services the insurance company does or does not cover.

If your insurance carrier's "Criteria" for Testosterone Replacement Therapy does not cover or restricts coverage for services provided by NexGen Health and Wellness, you will be responsible to arrange payment for the specific services that are not covered. We are under contract with your insurance carrier to bill only for services that fall under the "Criteria" of covered benefits. We cannot bill for services that are deemed "experimental". In some cases, Testosterone Replacement Therapy is considered "experimental" by specific insurance companies if the strict "Criteria" is not met.

LAB BILLING: Please be aware that NexGen Health and Wellness has no role in or control over billing issues related to clinical laboratory fees, however, we will try in every effort to assist you in efforts to correct lab billing issues if they arise. If you have questions about bills received for laboratory charges or insurance coverage available to you, please contact the clinical laboratory in question and/or your insurance carrier. Please understand that we cannot know which tests are covered by your individual insurance. We also cannot be responsible when you and/or your employer choose a high deductible insurance plan. Our interest is in providing you with quality medical care, utilizing appropriate laboratory testing. We will try to accommodate alternative lab companies for your lab work if your insurance requires it.

Current policies in the "ACA" Affordable Care Act may delay payment of your claims due to nonpayment of policy premiums by the patient. If your insurance delays, denies or pays and then recoups the payment of your claims due to non-payment of the policy premium, you will be responsible to pay the claim in full in accordance with our "Financial Policy" guidelines. I understand that, if my account is referred to a collection specialist due to non-payment, I will pay any applicable collection fees.

INITIALS:

_____ I HAVE READ THIS FINANCIAL AGREEMENT, ASKED ANY QUESTIONS I HAVE ABOUT IT, AND AGREE TO ITS TERMS

_____	_____	_____/_____/_____
Patient Name	**Patient Signature**	**Date**

Revised 10/30/19