SYNERGENX
PHYSICIAN SERVICES, PLLC

WELCOME TO SYNERGENX!

How did you hear about us?

☐ **Billboard**	☐ **Commercial/ TV**	☐ **Employee/ Family**	☐ **Facebook**	☐ **Flyer**	☐ **Former Patient**
☐ **Free T-Test Card**	☐ **Friend**	☐ **Google**	☐ **Gym**	☐ **Health Fair**	☐ **Internet**
☐ **Mailer**	☐ **Marketing Material**	☐ **Patient Referral**	☐ **Prior LowT**	☐ **Radio**	☐ **Referring Provider**
☐ **Shopping Cart**	☐ **Walk-In/ Drive-By**	☐ **Web Ad**	☐ **Website (SynergenX)**	☐ **Weight Loss Patient**	☐ **Work**

If someone referred you, whom/ Other?: _____

Last Name: _____ First Name: _____ M: _____

Preferred Name: _____ Date of Birth: _____ Age: _____ Gender at Birth: ☐ Male ☐ Female

Race & Ethnicity: ☐ American Indian or Alaska Native ☐ Black or African American

☐ Asian or Pacific Islander ☐ White ☐ Other Race: _____

Address: _____

City, State/ Zip Code: _____

Name of Insurance: _____

Preferred Pharmacy: _____

Preferred method of contact: ☐ E-mail ☐ Text May we send you a text reminder the day before your appointment? ☐ Yes ☐ No

E-mail: _____

Home Phone: _____ Cell Phone: _____

Have you experienced the following Primary Symptoms?

- ☐ Decreased Libido
- ☐ Decreased Spontaneous Erection
- ☐ Breast Discomfort
- ☐ Gynecomastia
- ☐ Testes that are less than 2.5cm in length
- ☐ Unusual Sweating
- ☐ Decrease in Testicular Size
- ☐ Hot Flashes
- ☐ Loss of Axillary or Pubic Hair

Have you experienced the following Secondary Symptoms?

- ☐ Weight Gain
- ☐ Lack of Energy
- ☐ Fall Asleep After Dinner
- ☐ Sleep Disturbances
- ☐ Lost Height
- ☐ Decreased Enjoyment of Life
- ☐ Decreased Muscle Mass
- ☐ Deterioration of Work Performance
- ☐ Decreased Ability to Play Sports
- ☐ Decreased Strength/Energy
- ☐ Sad, Grumpy or Moody
- ☐ Problems with Memory/Concentration

Do you have or have you had any of the following:

☐ Prostate or Breast Cancer ☐ Uncontrolled Heart Failure or Uncontrolled Blood Pressure ☐ Stroke

☐ Heart Attack ☐ Blood Clot in Legs, Arms, or Lungs ☐ Sleep Apnea w/o CPAP Use ☐ Desire Fertility

Have you been on testosterone or been exposed to testosterone previously? ☐ Yes ☐ No

Consent to have Blood Drawn for Treatment / Testing

I authorize the medical staff at SynergenX to obtain a blood sample to determine my testosterone and PSA levels, as well as any additional appropriate laboratory testing as determined in the professional discretion of the medical staff.

_____ Patient Signature

_____ Date

Office Use Only

Date of Blood Collection: _____ Time of Blood Collection: _____

Weight: _____ Height: _____ Blood Pressure: _____

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INSURANCE POLICY HOLDER INFORMATION (if different than above)	
Patient Name (Last, First MI):	
Date of Birth:	Social Security Number (SSN):
Employer:	Preferred Phone:
Insurance Name:	
Insurance ID #:	Group / Policy #:
Guarantor Name (Last, First MI):	
Relationship (self / spouse / other):	
Date of Birth (if different from above):	Social Security Number (SSN):

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Men's Hormone Replacement Therapy Consent Form

It is important to SynergenX Health Clinic that you understand the risks and benefits associated with Testosterone Replacement Therapy (TRT) before beginning or continuing treatment. TRT is not a new area of medicine and is used for the treatment of a medical condition known as hypogonadism in males. You should also be aware of alternatives to TRT, including not receiving TRT treatment. It is important that you consider the information provided and discuss the information carefully with your provider. Be sure that you are doing what is right for you. If you are unsure, then you should refuse and/or discontinue treatment.

The hormones that may be prescribed as part of your treatment may include Progesterone, and Testosterone as well Vitamin D, B12 and other dietary supplements, where indicated. Recommended treatment in some instances may include "off-label" drug use of an approved FDA medication, such as progesterone in men. Testosterone is FDA-approved only for use in men who lack or have low testosterone levels in conjunction with associated symptoms. These symptoms are often related to male andropause, or aging, and may include decreases in energy and motivation, poor concentration or memory, feelings of depression or irritability, sleep disturbances, reduced muscle mass, increased body fat, and reduced sexual desire or libido. These symptoms may be treatable in hypogonadal males utilizing testosterone. The therapeutic objective of TRT is to restore normal testosterone levels, helping to reduce these symptoms. There are a number of potential side effects related to TRT. You should discuss each of these with your medical provider. Side effects may include increased red blood cells, acne, sleep apnea, breast enlargement, testicular atrophy, lowered sperm count, mood swings, injection site reactions such as bleeding, pain, swelling, redness, or infection, increased estrogen production, or fluid retention. TRT is not recommended for patients who have breast or prostate cancer, or who are thinking about becoming parents. You should also be aware that some recent studies have associated TRT with increased risk for adverse cardiovascular events, such as blood clots, heart attacks, or strokes, in certain types of patients. If you have a history of cardiac or urologic problems, your provider may require clearance from your cardiologist or urologist prior to initiating treatment. Each patient's own risks can vary depending upon health history and lifestyle. It is important that you provide an accurate and complete medical history to your provider.

Please tell your provider if you have used alcohol or illicit drugs prior to your treatment visit.
You and your health care provider need to discuss the risks and benefits of treatment before you start or continue treatment.

Patient:
"This is my consent for SynergenX, including any physician, mid-level provider or nurse who works with the SynergenX Physician Services, to begin treatment for Hormone Replacement Therapy.

_____ I have read and understand that there may be complications arising from or related to treatment as described above and have been explained. I have had an opportunity to discuss my complete past medical and health history including any serious problems and/or injuries, as well as my family history of diseases and conditions, with my provider. All of my questions concerning the risks, benefits, and alternatives to treatment have been answered. I am satisfied with the answers and desire to commence treatment, knowing the risks and potential side effects involved.

_____ I understand that I will have periodic blood tests to monitor my blood levels of testosterone and I consent to such testing. I understand that the physical exam by my SynergenX provider does NOT replace a full physical exam by my personal physician, and I agree to have my personal physician (not SynergenX Health Clinic) perform a full physical exam including a lipid profile, cholesterol profile, digital rectal exam, and full metabolic panel, not less than annually.

_____ I understand that Autonomic Nervous System testing will be completed, and the results will be discussed via a separate TeleMedicine appointment.

_____ I understand that each patient is different and there are no guarantees as to results obtainable from TRT treatment. TRT is not a cure, and if I stop treatment, symptoms may return or worsen.
I am not currently attempting to father children. If this changes, I will advise my provider at SynergenX immediately.

_____ I do not have and have not been diagnosed with cancer".

Consent to Have Blood Drawn for Treatment/Testing

I authorize the medical staff at SynergenX to obtain a blood sample for the purpose of determining specific laboratory test levels.

Consent to Obtain Medication History

I authorize the SynergenX to obtain my medication history from the e-prescribing network system. This information will be used by the providers of the SynergenX Health Clinic for the sole purpose of keeping a current and accurate listing of medications.

Patient Statement of Understanding

I have read and fully understand the above information related to insurance and participation in SynergenX treatment program. I have also had the opportunity to ask questions regarding these issues. I am aware that I will receive an appropriate receipt of payment for my personal use as I see fit to do so. I understand the specifics of these receipts and limitations as described in this document. I accept these specific policy rules.

Printed Name:	Date:
Patient Signature:	

Provider

"I have reviewed each of the foregoing with the patient, including discussing the potential risks and benefits of treatment, the patient's complete past medical and health history and relevant family medical history. The patient has been provided the opportunity to ask questions concerning the risks, benefits, and alternatives to treatment, and desires to **{Circle One}** commence / refuse treatment".

Provider Signature:	Date:

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AUA SYMPTOM SCORE (AUASS)

Name (Last, First): _____ **DOB:** _____ **Today's Date:** _____

During the Past Month…	Not at All	Less Than 1 Time in 5	Less Than Half the Time	About Half the Time	More Than Half the Time	Almost Always
How often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
How often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
How often have you found you stop and start again several times when you urinate?	0	1	2	3	4	5
How often have you found it difficult to postpone urination?	0	1	2	3	4	5
How often have you had a weak urinary stream?	0	1	2	3	4	5
How often have you had to push or strain to begin urination?	0	1	2	3	4	5
	None	**1 Time**	**2 Times**	**3 Times**	**4 Times**	**5 or More Times**
How many times per night did you typically get up to urinate?	0	1	2	3	4	5

Add the scores for each number above and write the total in the space below.

TOTAL: _____

Symptom Score: **1-7 (mild)** **8-19 (moderate)** **20-35 (severe)**

Provider Signature: _____

QUALITY OF LIFE (QOL)

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
How would you feel in you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	0	1	2	3	4	5	6

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*****CLINIC USE ONLY*****			
Date:		**MRN:**	
Name:			
Height:	**Weight:**	**Goal Weight:**	
B/P:		**Pulse:**	**Resp:**
BMI	**PBF**	**DLM**	**BFM**
ICW	**ECW**	**VF**	**BMR**

PLEASE PLACE A CHECK IN THE BOXES, IN RELATION TO YOUR HISTORY AND SYMPTOMS

Chief Complaint / Reason for Visit:

☐ Fatigue ☐ Decreased Sex Drive (Low Libido) ☐ Erectile Dysfunction ☐ Decreased Muscle Mass ☐ Weight Concerns ☐ Mood Concerns

Symptoms began: _____months / years ago.

Severity of Symptoms: Mild Mild to Moderate Moderate Severe

Any Modifying Factors: _____ Timing of Symptoms: _____

Patient Health History

Have you had Comprehensive physical exam within the last 12 months? ☐ Yes ☐ No
Have you had an EKG in the last 12 months? ☐ Yes ☐ No
If Yes, was it normal? ☐ Yes ☐ No

Have you had a prostate exam in the last 12 months? ☐ Yes ☐ No
If Yes, was it normal? ☐ Yes ☐ No

Allergies to Medications

Medication Name	Reaction

Prescribed Medications & Over-the-Counter Drugs, Dietary Supplements (including vitamins, inhalers, etc.)

Medication Name	Strength	Frequency

Review of Symptoms

Check which of these symptoms are troublesome and have persisted over time

Androgen Deficiency

Primary Symptoms

- ☐ Decreased Sexual Desire (Low Libido)
- ☐ Decreased Spontaneous Erections
- ☐ Breast Discomfort
- ☐ Gynecomastia
- ☐ Testes Less Than 2.5cm in Length
- ☐ Unusual Sweating
- ☐ Noticeable Decreased in Testicular Size
- ☐ Hot Flashes
- ☐ Loss of Axillary or Pubic Hair

Secondary Symptoms

- ☐ Weight Gain
- ☐ Lack of Energy
- ☐ Fall Asleep After Dinner
- ☐ Sleep Disturbances
- ☐ Lost Height
- ☐ Decreased Enjoyment of Life
- ☐ Decreased Muscle Mass
- ☐ Recent Deterioration of Work Performance
- ☐ Decreased Ability to Play Sports
- ☐ Decreased Strength/Energy
- ☐ Sad, Grumpy or Moodiness
- ☐ Problem with Memory/Concentration

Thyroid

Thyroid Excess	Thyroid Deficiency
☐ Heat Intolerance	☐ Cold Intolerance
☐ Voice Hoarseness	☐ Constipation
☐ Heart Palpitations	☐ Fatigued/Weakness
☐ Weight Loss	☐ Unexplained Weight Gain
☐ Tremors/Shakiness	☐ Inability to Lose Weight
☐ Diarrhea	☐ Stress
☐ Nervousness/Anxious/Panic Attacks	☐ Cold Body Temperature
☐ Muscle Weakness	☐ Irritable
☐ Difficulty Conceiving/Infertility	☐ Lack of Motivation
☐ Coarse Dry Skin	☐ Muscle Cramps
☐ Insomnia	☐ Aches/Pains

Sexual Function

☐ Loss Morning Erections	☐ Loss of Spontaneous Erections	☐ Trouble Getting an Erection
☐ Trouble Keeping an Erection	☐ Decreased Sexual Desire (Low Libido)	☐ Premature Ejaculation
☐ Delayed Ejaculation		

Nervous System

- ☐ Heat Intolerance
- ☐ Numbness/Tingling in Extremities
- ☐ Excessive Sweating
- ☐ Lack of Sweating
- ☐ Tremors/Shakiness
- ☐ Frequent Urination/Inability to Control Bladder
- ☐ Nervousness/Anxiety/Stress
- ☐ Dizziness with Standing
- ☐ Swelling in Extremities
- ☐ Blueish Fingers/Toes when Cold
- ☐ Extreme Irritability/Anger/Tension
- ☐ Blurry Vision
- ☐ Inappropriate Weight Loss
- ☐ Exercise Intolerance
- ☐ Pain in Extremities

Medical History

Check which of these symptoms, disorders, conditions, or illnesses pertain to your history
This includes medical conditions you take or have taken medications for or if you have been diagnosed previously

History of Cardiac Disorder / Event ☐ Negative

- ☐ Myocardial Infarction (Heart Attack)
- ☐ Cerebrovascular Accident (Stroke, Mini-stroke/TIA, Hemorrhage)
- ☐ Thrombosis / Embolism (Blood Clot)
- ☐ Coronary Artery Bypass Graft Surgery (CABG)
- ☐ Aortic Valve Disorder or Replacement
- ☐ Mitral Valve Disorder or Replacement
- ☐ Endocarditis/Pericarditis
- ☐ Cardiomyopathy (Enlarged Heart)
- ☐ Cardiac Conduction Disorder (AV Block, Bundle Branch Block)
- ☐ Cardiac Arrhythmia (Atrial Fib/Flutter, Tachycardia)
- ☐ Heart Failure (Congestive Heart Failure)
- ☐ Pacemaker/Defibrillator Placement

Past Medical History ☐ Negative

- ☐ Prior Hormone Replacement Therapy
- ☐ Sleep Apnea ☐ CPAP in Use
- ☐ Snoring
- ☐ Chronic Kidney Disease
- ☐ Abnormal Liver Function
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ High Cholesterol
- ☐ Peripheral Artery Disease
- ☐ Chronic Lymph Node Enlargement
- ☐ Hypogonadism
- ☐ Inability to impregnate despite unprotected sex >1 year
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Enlarged Thyroid
- ☐ Depression
- ☐ Anxiety
- ☐ HIV
- ☐ Mumps
- ☐ COPD/Emphysema
- ☐ Insomnia/Sleep Disorder (includes Shift Work Sleep Disorder
- ☐ Seizures
- ☐ Headaches (Frequent)
- ☐ Anemia
- ☐ Excess Iron Buildup
- ☐ Bleeding Disorder
- ☐ Enlarged Prostate
- ☐ Prostate Cancer
- ☐ Cancer
- ☐ Cardiovascular Disease
  - ☐ Blood Clot (DVT/Pulmonary Embolism)
  - ☐ Chest Pain
  - ☐ Heart Attack
  - ☐ Heart Failure (CHF)
  - ☐ Stroke or TIA
- ☐ Acid Reflux
- ☐ Gout
- ☐ Obesity
- ☐ Cottonseed Allergy
- ☐ Neuropathy in Extremities
- ☐ Pain in Extremities
- ☐ Excessive Sweating
- ☐ Lack of Sweating
- ☐ Blurry Vision
- ☐ Irritable Bowel Syndrome
- ☐ Frequent Urination
- ☐ Dizziness with Standing
- ☐ Blueish Fingers/Toes when Cold
- ☐ Neuro-degenerative Disease (Parkinson's, Alzheimer's, ALS)
- ☐ Other: _____
- ☐ Other: _____

Past Surgical History ☐ No History of Genitourinary Surgery

- ☐ Vasectomy
- ☐ Other urinary system surgeries: _____
- ☐ Other surgeries: _____

Family History ☐ Negative

☐Family History of Prostate Cancer
☐ First Degree Relative: _____
☐ Family History of Cardiovascular Disease
☐ Heart Attack ☐ Stroke
☐ Family History of Endocrine Disease
☐ Diabetes ☐ Hypothyroidism ☐ Delayed Puberty ☐ Reproductive Disorder
☐ Family History of Breast Cancer
☐ Family History of Ovarian cancer
☐ Other

Social History

Exercise	How often are you physically active for 20 minutes or longer? ☐ Never ☐ 1-2x/ week ☐ 3-4x/ week ☐ >5x/ week			
	Which type(s) of exercise do you do? (check all that apply) ☐ Walking ☐ Running ☐ Weights ☐ Other: _____			
	Do you have any barriers that limit your ability to safely exercise? ☐ Yes ☐ No Please check all that apply: ☐ Work ☐ Family ☐ Energy Level ☐ Medical Condition ☐ Pain ☐ Motivation ☐ Other: _____			
Caffeine	Rank your caffeine intake: ☐ High	☐ Medium	☐ Low	☐ None
	What do typically drink during the day? ☐ Water ☐ Juice ☐ Tea ☐ Cola ☐ Diet Cola ☐ Coffee ☐ Other: _____			
	How many cups/cans per day? _____			
Alcohol	Do you drink alcohol?			☐ Yes ☐ No
	If yes, what kind? ☐ Beer	☐ Liquor	☐ Wine	
	How many drinks per week? ☐ 0	☐ 1-3	☐ 4-6	☐ >6
Tobacco	Do you use tobacco?			☐ Yes ☐ No
	☐Cigarettes – pks/day: _____ ☐ Other: _____ How many years? _____			
Drugs	Do you currently use recreational or street drugs?			☐ Yes ☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes ☐ No
Sex	Are you sexually active?			☐ Yes ☐ No
	If yes, are you trying for a pregnancy?			☐ Yes ☐ No
	Do you desire more children?			☐ Yes ☐ No
	If not trying for a pregnancy, list contraceptive or barrier method are you using:			
Diet	Are you dieting?			☐ Yes ☐ No
	If yes, are you on a physician prescribed medical diet?			☐ Yes ☐ No
	How many meals do you eat on an average day?			
	Rank your salt intake: ☐ High	☐ Medium	☐ Low	
	Rank your fat intake: ☐ High	☐ Medium	☐ Low	

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Occupation:

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*******SynergenX Clinician Use Only*******

Physical Exam: _____

Impression / Diagnosis:

- ☐ Hypogonadism
- ☐ Fatigue
- ☐ Muscle Weakness
- ☐ Hypoactive Sexual Desire (low libido)
- ☐ Erectile Dysfunction
- ☐ Testicular Atrophy
- ☐ Benign Prostatic Hyperplasia
- ☐ Elevated PSA
- ☐ Mild Cognitive Impairment (memory)
- ☐ Abnormal EKG
- ☐ Hypertension
- ☐ Elevated BP w/o HTN
- ☐ Metabolic Syndrome
- ☐ Hyperlipidemia
- ☐ Diabetes Mellitus Type I
- ☐ Diabetes Mellitus Type II
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Obstructive Sleep Apnea
- ☐ Insomnia
- ☐ Sleep Disturbances
- ☐ Anemia
- ☐ GERD
- ☐ Lower Back Pain
- ☐ Joint Pain
- ☐ Gout
- ☐ Dietary Counseling and Surveillance
- ☐ Overweight
- ☐ Obesity
- ☐ Morbid Obesity
- ☐ Vitamin D Deficiency
- ☐ Vitamin B12 Deficiency
- ☐ Other: _____

Testosterone Level: _____ cFT: _____ PSA: _____

Treatment: Testosterone Injection Today: _____ AUA: _____

Labs: TT SHBG PSA E2 TSH Prog FSH LH HGH Prolactin DHEA-S Vit D CBC CMP

Optional Labs: Vit B12 Lipid Panel fT3 fT4 A1c Ferritin Iron Studies

Plan: SXNP MRI(TT<150) SXNPNOSHOT(T low, but no inj) NPFERT3(T low, wants fertility)

_____ Provider Signature

_____ Date

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Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments

Please select one of the following payment options:

Assignment of Benefits- Insurance

☐ I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), private insurance and any other health/medical plan to issue payment check(s) directly to SynergenX Physician Services, PLLC. for medical services rendered to me and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Insurance Waiver and Payment Agreement- Self Pay

☐ I have chosen to be self-pay for health care services provided by SynergenX Physician Services, PLLC. I have decided to be self-pay even though I may have health insurance that covers these services and waive my right to have a claim submitted to my insurance company on my behalf. I agree to pay for services in the office on the date they are performed.

Authorization to Release Information

I hereby authorize SynergenX Physician Services, PLLC to: (1) release any information necessary to insurance carriers regarding my illness and treatments: (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from SynergenX Physician Services, PLLC on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Authorization to Appeal

I hereby voluntarily authorize SynergenX Physician Services to appeal the determination concerning reimbursement for treatment performed ___/____/____ on my behalf, as my Designated Representative, and, as a part of the appeal, I hereby authorize insurance company in its decision letter and in connection with the processing of my appeal, to communicate with my Designated Representative, SYNERGENX PHYSICIAN SERVICES PLLC in all aspects of the appeal. I understand these communications may contain the following:

All medical and financial information contained in my insurance file (as related to this claim only), including but not limited to treatment records and information relating to my treatment in connection with the determination which is being appealed. Some of the shared information may be considered "protected health information" and will be included in the disclosed information to the designated representative. I understand this information is privileged and confidential and will only be released as specified in this authorization, or as required or permitted by law. This authorization will remain in effect until revoked by me in writing. I also understand that I may revoke this authorization in writing at any time.

The undersigned certifies that he/she read and understands the foregoing, and is either the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accept terms.

_____ _____

Patient/Responsible Party Signature Date

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SynergenX Physician Services, PLLC HIPPA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, and healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected Health Information, or PHI, is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related healthcare services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operations of the physicians practice, and any other use required by law.

Treatment
We will only use and disclose your protected health information to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides you care to you, or provide it to a physician whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment
Your protected health information will be used as needed to obtain payment for your health care services.

Healthcare Operations
We may use or disclose, as needed, your protected health information In order to support the business activities of your physician's practice. These activities include but are not limited to quality assessment, employee review, training of medical students, and licensing. For example, we may call you be name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointments.

We may use or disclose your protected health information in the following situations without your authorization: as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity, and national security. Under the law, we must also make disclosures to you, and when required by the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted & Required Uses and Disclosures
Disclosures will be made only with your authorization or opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Individual Rights:

1. **You have the right to inspect and receive a copy of your protected health information**. Our practice will accept such requests in writing. Under federal law, however, you may not inspect or receive a copy of the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

2. **You have the right to request a restriction on the disclosure of your protected health information**. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends whom may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of our protected health information, your health information will not be restricted. You then have the right to use another healthcare professional.

3. **You have the right to request to receive confidential communications from us by an alternative means or at an alternative location**.

4. **You have the right to obtain a paper copy of this notice from us**.

5. **You have the right to receive an accounting of certain disclosure we have made, if any, of your protected health information**. We reserve the right to change the terms of this notice and will post any changes in our waiting areas. You then have the right to object as provided in this notice.

Complaints
You may file any complaints with our Privacy Officer, Paula Childs, at (281) 713-4384, or with the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

SynergenX Physician Services, PLLC Receipt of Notice of Privacy Practices

SynergenX Physician Services, PLLC® reserves the right to modify the privacy practices outlined in this notice.
By signing below, I am indicating that I have received a copy of the Notice of Privacy practices for **SynergenX Physician Services, PLLC®.**

Printed Name:	Patient Signature:	Date:

SYNERGENX
PHYSICIAN SERVICES, PLLC

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

NAME OF PATIENT OR INDIVIDUAL

_____ _____ _____
Last **First** Middle

Date of Birth: _____

Address: _____

City: _____ State: ____ Zip Code: _____

Phone: (____)_____ ALT Phone: (____)_____

Email Address (required): _____

Release records via: ☐ Electronic copy ☐ Paper copy

**charges may apply*

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name: _____

Address: _____

City: _____ State: ____ Zip Code: _____

Phone: (____)_____ Fax: (____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name: _____

Address: _____

City: _____ State: ____ Zip Code: _____

Phone: (____)_____ Fax: (____)_____

I understand that:

1. **THIS AUTHORIZATION IS VOLUNTARY, AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE.**

2. I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).

3. I may revoke this authorization at any time by notifying SynergenX Physician Services, PLLC in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.

4. SynergenX Physician Services, PLLC agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.

REASON FOR DISCLOSURE
(choose only one option below)

☐ Treatment/Continuing Medical Care
☐ Personal Use
☐ Billing or Claims
☐ Insurance
☐ Legal Purposes
☐ Disability Determination
☐ School
☐ Employment

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed.

☐ ALL Health Information
☐ Physician's Orders
☐ Progress Notes
☐ Pathology Reports
☐ History/ Physical Exam
☐ Patient Allergies
☐ Discharge Summary
☐ Past/ Present Medications
☐ Diagnostic Test Reports
☐ Billing Information
☐ Lab Results
☐ Consultation Reports
☐ EKG/ Cardiology Reports
☐ Other _____

Records for the date(s) of service ranging from _____ to _____ (REQUIRED)

In addition, I authorize that this will include health information relating to (check if applicable):

☐ HIV/ AIDS Infection ☐ Drug/ Alcohol Abuse ☐ Genetic Testing

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Patient Name: _____ **Date:** _____

This authorization will expire one year from the date of signing.

Patient Signature: _____ Patient ID #: _____

SYNERGENX
PHYSICIAN SERVICES, PLLC

Important Information about the Authorization to Disclose Protected Health Information

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)).

Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records.

(Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.

SYNERGENX
PHYSICIAN SERVICES, PLLC

Authorized Agent Form

I hereby authorize SynergenX Physician Services, PLLC to serve as my agent for purposes of holding and managing my compounded prescription medications prepared and dispensed by Empower Pharmacy pursuant to the written medication of my Provider. These prescription medications are to be administered in my Provider's office and is both medically necessary and in my best health care interest for my Provider's office to hold and manage my prescription. This consent form will serve as my authorization and can be found in my electronic medical record.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

SYNERGENX
PHYSICIAN SERVICES, PLLC

If Considering Weight Loss Products, Please Fill Out

It is important to SynergenX that you understand the risks and benefits associated with Pharmaceutical Weight Loss Therapy before beginning or continuing treatment.

If you have a history of cardiac problems, your provider may require clearance from your cardiologist prior to initiating treatment. Each patient's own risks can vary depending upon health history and lifestyle. It is important that you provide an accurate and complete medical history to your provider.

"This is my consent for SynergenX, including any physician, mid-level provider or nurse who works with the SynergenX Physician Services, to begin treatment for Weight Loss or Hormone Replacement Therapy.

_____ I have read and understand that there may be complications arising from or related to treatment as described above and explained by my treating medical provider. I have had an opportunity to discuss my complete past medical and health history including any serious problems and/or injuries, as well as my family history of diseases and conditions, with my provider. All of my questions concerning the risks, benefits, and alternatives to treatment have been answered. I am satisfied with the answers and desire to commence treatment, knowing the risks and potential side effects involved.

_____ I understand If any of reactions or side effects occur, medication should be discontinued immediately, and I will seek appropriate medical attention.

_____ I understand that the physical exam by my SynergenX provider does NOT replace a full physical exam by my personal physician, and I agree to have my personal physician (not SynergenX) perform a full physical exam including a lipid profile, cholesterol profile, and full metabolic panel, not less than annually.

_____ I understand that any pre-existing gallbladder dysfunction or gallstones I have (whether or not I am aware of it) may become exacerbated due to the low-fat nature of the HCG Diet Program or as a consequence of the rapid weight-loss. This may result in the need to have my gallbladder surgically removed.

_____ I understand that HCG is a hormone that has the potential to increase the risk of blood clots in genetically susceptible people. If I have a personal or family history of blood clots, I accept this increased risk and agree to take aspirin or other recommended supplements to try to counteract the blood clot risk.

_____ I further understand that not complying with the dosage recommendations and dietary restrictions could increase risks and alter my results from the program. If I do not follow these recommendations and restrictions, I agree to release SynergenX and their medical providers and facility from any liability arising as a result of this.

_____ I understand how to take and administer and agree to take the exact dose prescribed by my provider.

_____ I understand that weight loss treatment is purely elective and that it may not be deemed medically necessary by insurance companies. Also, I understand that some of the recommended medications are not specifically approved by the FDA and may be used off-label.

_____ I understand that each patient is different and there are no guarantees as to results obtainable from treatment. Treatment is not a cure, and if I stop treatment, symptoms may return or worsen.

_____ I do not have and have not been diagnosed with “cancer". I am aware that therapy may awaken latent cancers, may promote metabolic disorders such as diabetes and may exacerbate the decline of other endocrine functions by changing and/or distorting essential hormonal interactions.

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Women Only

_____ I am not currently pregnant or breast feeding. If this changes, I will advise my provider at SynergenX immediately.

_____ I understand that if I am predisposed to ovarian cysts or polycystic ovarian syndrome, there is an increased risk of a cyst rupture due to ovarian stimulation from the HCG hormone, which may or may not require surgery.

Consent to Have Blood Drawn for Treatment/Testing

I authorize the medical staff at SynergenX to obtain a blood sample for the purpose of determining specific laboratory test levels.

Consent to Obtain Medication History

I authorize the SynergenX to obtain my medication history from the e-prescribing network system. This information will be used by the providers of the SynergenX Health Clinic for the sole purpose of keeping a current and accurate listing of medications.

Patient Statement of Understanding

I have read and fully understand the above information related to insurance and participation in SynergenX treatment program. I have also had the opportunity to ask questions regarding these issues. I am aware that I will receive an appropriate receipt of payment for my personal use as I see fit to do so. I understand the specifics of these receipts and limitations as described in this document. I accept these specific policy rules.

Printed Name:	Date:
Patient Signature:	

Provider

"I have reviewed each of the foregoing with the patient, including discussing the potential risks and benefits of treatment, the patient's complete past medical and health history and relevant family medical history. The patient has been provided the opportunity to ask questions concerning the risks, benefits, and alternatives to treatment, and desires to **{Circle One}** commence / refuse treatment".

Provider Signature:	Date: