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 symptoms?

☐ Decreased libido (sex drive)	☐ Poor concentration	☐ Irregular or missed periods	☐ Fatigue
☐ Hot flashes	☐ Pain during sex	☐ Breast discomfort	☐ Sleeplessness
☐ Night sweats	☐ Vaginal dryness	☐ Weight gain	☐ Orgasmic changes
☐ Emotional changes (mood swings, mild depression, irritability)			

Last Well Woman Exam: _____ Last Mammogram: _____

****you may be asked to obtain current test results prior to starting hormone replacement therapy****

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

☐ 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 hormone therapy 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 hormone 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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Women's Hormone Replacement Therapy Consent Form

It is important to SynergenX that you understand the risks and benefits associated with Hormone Replacement Therapy (HRT) before beginning or continuing treatment. HRT is not a new area of medicine, however the treatment modalities employed by SynergenX may involve innovative therapies and there are no guarantees with respect to the treatment prescribed. You should also be aware of alternatives to HRT, including not receiving HRT treatment, leaving hormone levels as they are, and treating age-related diseases as they appear. It is important that you consider the information we provide 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.

Many women suffer from symptoms associated with inadequate hormone levels. These symptoms are often related to menopause or aging. Such symptoms may include inability to lose weight, vision loss due to macular degeneration, sleep difficulties, increased hot flashes, night sweats, decreased cognitive function, decreased libido, fatigue, or anxiety, and bone loss. These symptoms may be treatable utilizing hormones. The therapeutic objective of HRT is to optimize hormone levels, helping to reduce symptoms. HRT is considered by some insurance providers as a form of alternative medicine. This means that some treatment options at SynergenX may not be covered by your specific health insurance (different health insurers have different definitions in their policy documents). You will be required to separately pay for these services at the time they are rendered if your insurance does not cover them.

The hormones that may be prescribed as part of treatment may include Estrogen, Progesterone, and Testosterone, as well as other treatments for thyroid function, and Vitamin D and B12, where indicated. Recommended treatment in some instances may include "off-label" drug use of FDA-approved medications such as Testosterone. Off-label use means use of FDA-approved medications for additional indications, where determined to be appropriate by the treating physician. Currently, testosterone is only FDA-approved for use in men. If your treatment includes testosterone, your Provider must review the information on the following page with you before you commence treatment. There is a number of potential side effects related to HRT. You should discuss each of these with your Provider. Side effects may include bloating, breakthrough bleeding, breast swelling and tenderness, clitoral enlargement, fluid retention, weight gain, liver cysts, mood swings, increased red blood cells, acne, hair growth, vocal changes, sleep apnea, or heightened cholesterol levels. In some patients, there could be increased risks of endometrial, uterine, or breast cancer, blood clots, stroke, gallbladder disease, or high blood pressure. Certain types of HRT have a higher risk, and each woman's own risks can vary depending upon her health history and lifestyle. You and your Provider need to discuss the risks and benefits of treatment.

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 should not participate in HRT if you are, or are thinking of, becoming pregnant. You should not participate in HRT if you are at risk for becoming pregnant (premenopausal or not currently taking birth control) without specifically discussing the risks involved with your Provider. You should not participate in HRT if you have, or have been treated for, certain types of cancer.

"This is my consent for SynergenX, including any physician, health care provider or nurse who works with the SynergenX physicians, 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 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 that I will have periodic blood tests to monitor my blood levels of each hormone and I consent to such testing. I understand that the physical exam by SynergenX 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, mammogram, pap smear 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 HRT treatment. HRT is not a cure, and if I stop treatment, symptoms may return or worsen.

_____ I am not pregnant, and am not planning on becoming pregnant, and am not at risk of becoming pregnant. I do not have and have not been diagnosed with cancer.

_____ Prices for treatment have been fully explained to me and if my insurance does not cover treatment, I will be charged the current price for the therapeutic options I choose".

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 Physician Services 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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*****CLINICAL USE ONLY*****			
Date:		**MRN:**	
Name:			
Height:	**Weight:**	**Goal Weight:**	
B/P:		**Pulse:**	**Resp:**
BMI	**PBF**	**DLM**	**BFM**
SMM	**ECW**	**VF**	**BMR**

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

Chief Complaint / Reason for Visit:

☐ **Decreased Sex Drive** ☐ **Poor Concentration** ☐ **Irregular Missed Periods** ☐ **Fatigue**
☐ **Hot Flashes** ☐ **Pain During Sex** ☐ **Breast Discomfort** ☐ **Sleeplessness**
☐ **Night Sweats** ☐ **Vaginal Dryness** ☐ **Weight Gain** ☐ **Orgasmic Changes**
☐ **Emotional Changes (mood swings, mild depression, irritability)**

Symptoms began: _____months / years ago

Severity of Symptoms: Mild Mild to Moderate Moderate Severe

Any Modifying Factors: _____ Timing of Symptoms: _____

Patient Health History: Annual Exam, Menstrual/ Women's Health

Have you had comprehensive physical exam within the last 12 months? ☐ Yes ☐ No

First day of last menstrual period: _____ How often do you get your period? _____

Is your cycle: ☐ Regular ☐ Irregular Heavy, crampy, clotty periods: ☐ Yes ☐ No

Are you currently being treated for any of the following: ☐ Negative

☐ Polycystic ovarian disease (PCOS) ☐ Fibroids (breast or uterine) ☐ Endometriosis ☐ Benign tumors of reproductive organs

Any personal (past or current) treatment for cancer: ☐ Yes ☐ No

1st degree relative with any of the following: ☐ Negative or Unknown

☐ Uterine cancer ☐ Ovarian cancer ☐ Cervical cancer ☐ Breast cancer

Last Well Woman Exam: _____ Abnormal Pap smear results in the past: ☐ Yes ☐ No

Last Mammogram: _____ Abnormal Mammogram results in the past: ☐ Yes ☐ No

Method/ name of birth control: _____

Are you pregnant, trying for pregnancy, or breastfeeding? ☐ Yes ☐ No

Number of pregnancies: _____ Number of live births: _____

Allergies (medications, foods, latex, etc.)

Medication Name / Type	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)
- ☐ Breast Discomfort
- ☐ Breast Enlargement (Gynecomastia)
- ☐ Unusual Sweating
- ☐ 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

Estrogen

Estrogen Excess	Estrogen Deficiency
☐ Hot Flashes	☐ Night Sweats
☐ Breast Tenderness	☐ Hot Flashes
☐ Edema/Bloating	☐ Depression
☐ Emotional/Weepiness	☐ Memory Lapse
☐ Mood Swings	☐ Bladder Infections
☐ Foggy Thinking	☐ Painful Intercourse
☐ Red Flush on Face	☐ Vaginal Dryness
☐ Migraine Headaches	
☐ Insomnia	
☐ Weight Gain	
☐ Anxious / Depression	
☐ Heavy Bleeding	
☐ Gallbladder Problems	

Progesterone

Progesterone Excess	Progesterone Deficiency
☐ Drowsiness	☐ PMS/PMDD
☐ Edema	☐ Insomnia
☐ Breast Tenderness	☐ Early Miscarriage
☐ Mood Swings	☐ Mood Instability
☐ Loss of Libido	☐ Anxiety
	☐ Cyclical Headaches
	☐ Lumpy Breasts

Adrenals

Cortisol Excess		Cortisol Deficiency
☐ Sleep Disturbances	☐ Decreased Sexual Desire (Low Libido)	
☐ Heart Palpitations	☐ Hair Loss	☐ Sugar Craving
☐ Bone Loss	☐ Stress	☐ Allergies
☐ Headaches	☐ Increased Facial Hair	☐ Chemical Sensitivity
☐ Fatigue	☐ Increased Body Hair	☐ Stress
☐ Weight Gain – Waist	☐ Acne	☐ Cold Body Temperature
☐ Cold Body Temperature	☐ Nervous	☐ Irritable
☐ Loss of Muscle Mass	☐ Breast Cancer	☐ Arthritis
☐ Sugar Cravings	☐ Irritable	☐ Heart Palpitations
☐ Thinning Skin	☐ Anxious	☐ Aches/Pains
☐ Elevated Triglycerides	☐ Memory Lapses	

Thyroid	
Thyroid Excess	**Thyroid Deficiency**
☐ Heat Intolerance ☐ Voice has Become Hoarse ☐ Heart Palpitations ☐ Weight Loss ☐ Tremors/Shakiness ☐ Diarrhea ☐ Nervousness/Anxious/Panic Attacks ☐ Muscle Weakness ☐ Difficulty Conceiving/Infertility ☐ Coarse Dry Skin ☐ Insomnia	☐ Cold Intolerance ☐ Constipation ☐ Fatigued/Weakness ☐ Unexplained Weight Gain ☐ Inability to Lose Weight ☐ Stress ☐ Cold Body Temperature ☐ Irritable ☐ Lack of Motivation ☐ Muscle Cramps ☐ Aches/Pains
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) or Blockage (Stent Placement)
☐ 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
- ☐ COPD/ Emphysema
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ High Cholesterol
- ☐ Peripheral Artery Disease
- ☐ Chronic Lymph Node Enlargement
- ☐ Hypogonadism
- ☐ Inability to get pregnant despite unprotected sex >1 year
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Enlarged Thyroid
- ☐ Depression
- ☐ Anxiety
- ☐ ADD/ ADHD
- ☐ HIV
- ☐ Hepatitis
- ☐ Mumps
- ☐ Insomnia/ Sleep Disorder (includes Shift Work Sleep Disorder)
- ☐ Seizures
- ☐ Headaches (Frequent)
- ☐ Anemia
- ☐ Excess Iron Buildup
- ☐ Blood/ Clotting Disorder
- ☐ Arthritis/ Joint Pain
- ☐ Osteoporosis
- ☐ Gout
- ☐ Autoimmune Disorder
- ☐ Cancer
- ☐ Cardiovascular Disease
- ☐ Blood Clot (DVT/Pulmonary Embolism)
- ☐ Chest Pain
- ☐ Heart Attack/ Blockage
- ☐ Heart Failure (CHF)
- ☐ Stroke or TIA
- ☐ Acid Reflux
- ☐ Obesity
- ☐ 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

Hysterectomy: ☐ Partial ☐ Total Year: _____

Other reproductive system surgeries: _____

Other surgeries: _____

Other procedures: _____

Family History ☐ Negative

- ☐ Family History of Cardiovascular Disease
  - ☐ Heart Attack ☐ Stroke
- ☐ Family History of Endocrine Disease
  - ☐ Diabetes ☐ Hypothyroidism ☐ Delayed Puberty ☐ Reproductive Disorder
- ☐ Family History of Breast Cancer
  - If yes, what relation: _____
- ☐ Family History of Ovarian, Uterine, Cervical Cancer
  - If yes, what relation: _____
- ☐ Other: _____

Social History

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 you are using: _____		

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

Occupation:

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

Physical Exam: _____

_____

Impression / Diagnosis:

- ☐ Ovarian Dysfunction
- ☐ Menopause/ Perimenopause Symptoms
- ☐ Premenstrual Disorder (PMS)
- ☐ Symptomatic Premature Menopause (<40 years old)
- ☐ Menorrhagia (heavy bleeding)
- ☐ Dysmenorrhea (menstrual cramps)
- ☐ Female Orgasmic Disorder
- ☐ Hypoactive Sexual Desire (low libido)
- ☐ Fatigue
- ☐ Muscle Weakness
- ☐ Insomnia
- ☐ Obstructive Sleep Apnea
- ☐ Sleep Disturbance
- ☐ Hypertension
- ☐ Elevated BP w/o HTN
- ☐ Metabolic Syndrome
- ☐ Hyperlipidemia
- ☐ Diabetes Mellitus Type I
- ☐ Diabetes Mellitus Type II
- ☐ Hypothyroidism
- ☐ Sub-Clinical Hypothyroidism
- ☐ Hyperthyroidism
- ☐ GERD
- ☐ Vitamin D Deficiency
- ☐ Vitamin B12 Deficiency
- ☐ Upper Respiratory Infection
- ☐ Abnormal Liver Function Tests
- ☐ Abnormal Kidney Test
- ☐ Anemia
- ☐ Hemochromatosis
- ☐ Polycythemia
- ☐ Alopecia
- ☐ Acne
- ☐ Osteoporosis/ Osteopenia
- ☐ Arthritis/ Joint Pain
- ☐ Gout
- ☐ Lower Back Pain
- ☐ Abnormal EKG
- ☐ Normal EKG
- ☐ Other: _____

Extensive New Patient Panel:

TT SHBG E2 Prog Vit D DHEA-S FSH LH HGH TSH Prol CBC CMP FT3 FT4 Ferr Vit B12

Additional Labs (extra cost):

Lipid Panel A1c TPO Antibodies TG Antibodies IGF-1 Mag Iron & TIBC Uric Acid

Plan: SXNPW

_____ _____

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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WHRT New Patient and Retest Pricing Consent

We have consolidated payments and clinic visits to improve patient experience; offer additional time to deliver a higher level of care; and accommodate customized treatment plans developed by our Women's Health Specialists via a Telemedicine appointment. **Payment is due on date/time when labs are collected.**

New Women's Hormone Patient: SELF-PAY: $560 INSURED PAY: $_____

The initial bundle includes:

- Initial consult with a provider
- An extensive hormone panel drawn
- ANS testing and telemedicine review of results
- Body Composition Analysis
- Telemedicine appointment with a Women's Hormone Specialist to review lab results and determine your individualized treatment plan
- 90 days of medication *(retesting may occur sooner)*

Existing Women's Hormone Patient: SELF-PAY: $360 INSURED PAY: $_____

The bundle includes:

- Labs drawn
- Telemedicine appointment with a Women's Hormone Specialist to review lab results
- 90 days of medication *(retesting may occur sooner)*

Pellet Schedule*	Cream Schedule*
Week 1: New Patient labs collected ($560**) Week 2: Telemedicine discussion/ Medications ordered Week 3: Pellet insertion Week 9: Labs collected: assesses pellet efficacy, determines next pellet dose ($360**) Week 10: Telemedicine discussion/ Medications ordered Week 16: Pellet insertion Week 22: Labs collected: assesses pellet efficacy, determines next pellet dose ($360**) Week 23: Telemedicine discussion/ Medications ordered Week 29: Pellet insertion Week 35: Labs collected: assesses pellet efficacy, determines next pellet dose ($360**) Week 36: Telemedicine discussion/ Medications ordered Week 42: Pellet insertion ***Pellets are typically placed every 3-5 months and should be tested 4-9 weeks after placement to determine dosing for your next therapy***	Week 1: New Patient labs collected ($560**) Week 2: Telemedicine discussion/ Medications ordered Week 14: Labs collected: assesses cream efficacy, determines next cream dose ($360**) Week 15: Telemedicine discussion/ Medications ordered Week 27: Labs collected: assesses cream efficacy, determines next cream dose ($360**) Week 28: Telemedicine discussion/ Medications ordered Week 40: Labs collected: assesses cream efficacy, determines next cream dose ($360**) Week 41: Telemedicine discussion/ Medications ordered ***Creams should be retested 9-12 weeks after any dose change***

**This schedule is based on a Self-Pay standardized treatment plan and may vary slightly per patient, as might the results of using hormones. Approximate annual cost of basic Women's Health services: $2000*

***Payment is to be paid at the time of lab collection; rates may vary depending on insurance carrier.*

By signing below, each of the undersigned acknowledges that: (i) I have been provided a copy of the SynergenX Physician Services, PLLC WHRT NEW PATIENT AND RETEST PRICING CONSENT; (ii) I have read, understand, and agree to their provisions and agree to the specified terms; (iii) I agree to pay all charges due (or to become due) to SynergenX Physician Services, PLLC for the below patient's care and treatment, including co-payments and deductibles, as required or provided pursuant to my insurance plan and/or the insurance plan of another, as applicable; (iv) benefits, if any, paid by a third-party will be credited on the patient account; (v) regardless of my insurance status or absence of insurance coverage, I am ultimately responsible for the balance on the account for any services rendered; (vi) if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting the money owed, including court costs, collection agency fees, and attorneys' fees (to the extent allowed by law); and (vii) failure to pay when due may subject me to late payment charges and can adversely affect my credit report. I further agree that a photocopy of this WHRT NEW PATIENT AND RETEST PRICING CONSENT shall be as valid as the original.

ONCE I HAVE SIGNED THIS AGREEMENT, WHETHER BY ORIGINAL, FACSIMILE OR ELECTRONIC (".PDF") SIGNATURE, I AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN FULL FORCE AND EFFECT.

Patient Signature: _____ **Date:** _____

Patient Printed Name: _____ **DOB:** _____

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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

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

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:

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

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).

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.

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

If Considering Any Weight Loss Products, Please Fill Out Consent Form

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

_____ 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: