MediTouch Upload & Update

Entered By:_______________

Date:_________________

2019

Patient Information

Patient Name:______________________________ Date of Birth: _____/_____/_____ Gender: M / F

Address: ____ Apt,Suite,Unit#:_______________

City: ____________________________________ State:________________ ZIP:_______________

Home#:(______)______-________Work#:(______)______-________Cell#:(______)______-________

Occupation: __________________________________ Referred By:__________________________

Email:__________________________________ Marital Status: Single / Married / Divorced / Widowed

Are you currently covered by health insurance? **Yes / No**

Insurance Company:_________________________

Subscriber/Policy ID#:____________________________ Group#:____________________________

Are you the Primary Insured, Policy Holder? **Yes / No**

(If you answered No; please fill out the Policy Holder's information)

Policyholder's Name:__________________________ Policy Holder's Date of Birth: _____/_____/______

******PLEASE ALLOW OUR STAFF TO MAKE A COPY OF YOUR DRIVERS LICENSE & INSURANCE CARD******

Release of Medical Information

I _______________________, give permission for my protected health information to be disclosed for purposes of communicating results, findings, and care decisions to the family members listed below.

Name of Authorized Individuals	Relationship to Patient	Date of Birth
______________________________	______________________	___/___/____
______________________________	______________________	___/___/____
______________________________	______________________	___/___/____

______________________________ ______________________________ _____/_____/_____

Printed Name Signature Date

HIPAA – Notice of Privacy Practices

This notice, effective immediately, describes how medical information about you may be used and disclosed as well as how you can get access to this information. Please review carefully. Our office is required by law to maintain the privacy and confidentiality of your protected health information in addition to providing our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment – We may disclose your health care information to other healthcare professionals within our practice for treatment, payment, or healthcare operations.

Payment – We may disclose your health care information to your insurance company provider for payment or health care operations. We have your permission to disclose your health care information to your insurance company for appealing claims on your behalf.

We may disclose your health care information as necessary to comply with State Workers' Compensation laws, Public Health Authorities, Emergency situations, Judicial an Administrative proceedings, Law Enforcement and Medical Examiners. Your health care information may also be disclosed to Research that has been approved by an Institutional Review Board, when necessary to prevent a health or safety issue, to military or national security and government benefit purposes, for company approved marketing purposes, showing gratitude and appreciation for referrals and change of ownership.

We reserve the right to change and amend this Notice of Privacy Practices at any time. Our office is required by law to maintain the privacy of your health information as well as provide you with notice of its legal duties and privacy practices with respect to your health information.

I understand and have been provided with a Notice of Privacy Practices, which offers a description of the information uses and disclosures. I understand and had the right to review this notice prior to signing the consent, the right to object the use of my health information for directory purposes and the right to request restriction as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

________________________________ _____/_____/_____

Printed Name Date

____

Signature

Vitality Internal Medicine
18205 N. 51st Ave Ste 129
Glendale, AZ 85308

Vitality Internal Medicine
4653 S. Lakeshore Drive Ste 2
Tempe, AZ 85282

Vitality Internal Medicine
4643 N. 12th Street Ste 101
Phoenix, AZ 85014

Scottsdale Internal Medicine
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Scottsdale, AZ 85260

McKellips Internal Medicine
3049 E. McKellips Road Ste 5
Mesa, AZ 85213

Vitality Internal Medicine
10320 W. McDowell Road Ste 5015
Avondale, AZ 85392

Patient Responsibility & Assignment of Benefits

Our practice is committed to providing you with the best possible health care. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions or concerns about our fees, or any content written in our Financial Policy below.

As a courtesy, we will submit claims for all services rendered to your insurance company. Please note your individual health insurance policy is a contract between you and your insurance company, and we cannot guarantee benefit coverage and/or payment. Coverage is based on medical necessity, plan limitations, and guidelines. Please keep in mind that some of our services may not be covered by your insurance policy. By providing for care, you agree that you are responsible for all services and charges, regardless of your insurance.

While providing care for your medical need's certain tests and/or services are necessary for diagnosis, treatment, and maintenance of good health. All lab work performed in our office will be sent to Labcorp, Sonora Quest, or a third-party laboratory, and billed to your insurance. If these tests and/or services are not covered by your health insurance; you may receive a separate bill from Labcorp, Sonora Quest, or third-party laboratory for those services rendered.

It is important that you understand that you are responsible for all charges that may occur during your visit. In addition to paying for any insurance co-payment, co-insurance, or deductible balances at the time of service, you may also be responsible for services not covered by your insurance carrier. Insurance companies may set certain guidelines and/or limitations, understand it is your responsibility to abide by the guidelines set by your individual insurance policy. If your insurance carrier denies the medical claim, the patient is responsible for timely payment of the account.

Cancellation & Late Fees

A 24-hour notice is required if you are unable to keep your appointment. Missed appointments and appointments not cancelled within a 24-hour notice will be subject to a fee of $50.00 and must be paid before you are able to be rescheduled. ________ (Initial)

If you are more than 15 minutes late for your scheduled appointment (other than weekly TRT visits) and fail to call informing the practice in advance you will be subject to a late fee of $25.00. ________ (Initial)

I have read the financial policy for the practice and understand that I am responsible for all charges on my account. It is my financial responsibility to supply payment for any charges not covered by my insurance plan including, but not limited to co-insurance, co-payments, and deductibles. I understand that co-payments for the office are due at the time of service.

______________________________________ ______/______/______
Printed Name Date

____
Signature

Testosterone Consent Forms / Terms Of Acceptance

The goals of treatment are to help treat hypogonadism, restore levels to the upper range of normal, and improve you r quality of life. The effectiveness and safety of testosterone therapy has been examined by the American Academy of Family Physicians and there is no compelling evidence of major side effects resulting from testosterone.

By initialing below, I understand that the side effects of testosterone replacement therapy (TRT) can include:
(Please initial each line below)

1._____ Fluid retention: The problem of fluid accumulation may be observed. This may lead to leg or ankle swelling, worsening of congestive heart failure or high blood pressure.

2.______ Increase in Red Blood Cells: People undergoing testosterone replacement therapy may show increased red blood cells concentration and hemoglobin levels. I understand that red blood cells, hemoglobin and or hematocrit that is uncontrolled may lead to Thrombotic events including but not limited to: Arterial/venous thrombosis, cerebral vascular accident, deep venous thrombosis, pulmonary embolism, myocardial infraction. I was advised to give blood through a blood donation center at least once every four months to assist in avoiding any potential complications and side effects of TRT on red blood cell production.

3.______ Potential stimulation of existing prostate cancer and prostate tissue. Increased urination symptoms such as decreased stream or frequency.

4._______ Enlargement of Breast Tissues. This is the result of testosterone converting into estrogen. Breast tissues in both men and women are sensitive to estrogen.

5._______ Changes in cholesterol and lipid levels.

6._______ Acne or oily skin.

7._______ Decreased testicular size.

8._______ Decreased sperm count and possible infertility: I have been advised to supplement TRT with HCG therapy to slow the effects of testicular degeneration exacerbated by TRT.

9._______ I understand that Vitality Internal Medicine and Men's Vitality Center recommends I undergo regular and complete physical examinations by my own Primary Care Physician.

10.______ I understand that medicine is an art rather than an exact science, and that diagnosis and treatment may involve risks or injury.

11.______ All these conditions have been fully explained to me by my Vitality Internal Medicine and Men's Vitality Center provider.

12._______ I have had the chance to thoroughly discuss my health history with my Vitality Internal Medicine and Men's Vitality Center Provider.

______________________________________ ______/______/_______

Patient signature Date

______________________________________ ______/______/_______

Provider Signature Date

Lab Test Results Communication

The foundation of good healthcare is built on timely and thorough communication. We want to give solutions for those who may not be available to accept phone calls during traditional office hours. Additionally, we take our responsibility to protect your privacy seriously. Regardless of which option you choose, if at any time you have questions regarding test results we are happy to discuss them with you further. Carefully read the options below and choose the option that best fits your needs by initialing it. Thank you!

______ **Phone/Voicemail**

Please call me to review my test results. If you do not reach me, you may leave a detailed message on my voicemail with my results.

______ **Phone only**

Please call me to review my review my test results. If you do not reach me, please leave a message for a return call. I only want to receive test results by speaking to a staff member, and DO NOT want detailed messages left on my voicemail.

______ **Email only**

Please send my test results at ________________________________.

If I have any questions I will call the office and speak with a staff member.

______ **No call**

Please do not call, I will go over my test results at my next office visit.

Patient Name: ________________________ Phone Number: _______________

Patient Signature: ____________________________ Date: _________________

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Electronic Prescription Pharmacy Preference

Name ____________________________ Date __________________

Please choose your preferred retail and/or mail order pharmacy for approved prescriptions to be sent electronically.

Local Pharmacy:

Pharmacy Name: _______________________________ Phone Number: _______________

Address / Cross Streets:

____

____

Mail Order Pharmacy:

Pharmacy Name: _______________________________ Phone Number: _______________

Address / Cross Streets:

____

____

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HEALTH QUESTIONNAIRE

PATIENT NAME: ______________________________ DOB: ______________

CLINIC NAME: ______________________________ INSURANCE: ______________

Check any of the following symptoms you currently have or have had in the past 6 months:

☐Headaches/Migraines
☐Muscle Pain
☐Neck Pain
☐Back Pain/Spasm/Instability
☐Shoulder Pain
☐Hip Pain
☐Wrist Pain
☐Shortness of Breath
☐Asthma
☐COPD
☐Smoker
☐High Blood Pressure
☐Chronic Kidney Disease
☐Diabetes
☐High Cholesterol
☐Peripheral Artery Disease
☐Fast Heartbeat
☐Multiple Sclerosis
☐Low Blood Pressure
☐Tingling/Numbness in Hands, Arms, Legs
☐Sleep Apnea
☐Snoring
☐Daytime Sleepiness
☐Fainting/Almost Fainting
☐Disoriented
☐Loss of Awareness
☐Migraine with or without aura
☐Sinusitis
☐Post Nasal Drip
☐Red, Itchy or Watery Eyes
☐Runny or Stuffy Nose
☐Sneezing
☐Sore or Itchy Throat
☐Wheezing or Coughing
☐Frequent Ear Infections
☐Chronic Bronchitis
☐Ringing Ears
☐Itchy Skin, Rash, or Hives
☐Decreased Libido
☐Excessive/Frequent Menstruation
☐Malaise/Fatigue
☐Weight Loss/Gain
☐Night Sweats
☐Vitamin D Deficiency
☐Morbid Obesity
☐Type 1 Diabetes
☐Type 2 Diabetes
☐Diarrhea
☐Bloating/Gas
☐Loose Stools
☐Abnormal-Smelling Stool
☐Irritable Bowel
☐Cancer/MOHS on Skin
☐Diabetic Ulcer
☐Wound That Won't Heal
☐Skin Injury

______________________________ ______________________
Patient's Signature Date

OFFICE USE ONLY: Scheduled ____________________ Provider ____________________

☐Sphenopalatine Block (SPB)
☐Trigger Point Injections (TPI)
☐Joint Injections (hip, knee, shoulder) (JI)
☐Comprehensive CPX (CPX)
☐VSAT (VSAT)
☐Home Sleep Lab (HSL)
☐Video EEG (EEG)
☐Pharmacogenetic Testing (PGX)
☐DME (DME)
☐Environmental Allergy Testing (EAT)
☐Blood Wellness Panel (WP)
☐Red Advantage Blood Panel (RED)
☐Gastrointestinal Panel (GI)
☐Axolotl (AX)
☐Pharmacy (PHARM)

Health History Form

Your answers to this form will help your healthcare providers better understand your medical concerns and conditions.

Name ______________________________ Date of Birth _____________ Age _____ Today's Date __________

PAST MEDICAL HISTORY

Medical Problems/Hospitalizations (i.e. diabetes, cancer, high blood pressure, high cholesterol, depressions, ect.)	**Surgical History** (i.e. tonsillectomy, appendectomy, hernia, hysterectomy, colonoscopy, ect.) Include month/year

FAMILY MEDICAL HISTORY

Father ☐Living, Any Medical Conditions: ______________________________

☐Deceased, Cause of Death: ______________________________

Mother ☐Living, Any Medical Conditions: ______________________________

☐Deceased, Cause of Death: ______________________________

Brothers ____# ☐Living, Any Medical Conditions: ______________________________

☐Deceased, Cause of Death: ______________________________

Sisters ____# ☐Living, Any Medical Conditions: ______________________________

☐Deceased, Cause of Death: ______________________________

Specific Illness in Family History: (i.e. colon cancer, breast cancer, prostate cancer, heart disease, stroke, etc.) ☐None

If so, please state disease and who: ______________________________

SOCIAL HISTORY

Tobacco Use: ☐Never ☐Former ☐Current _____ #packs/day _____# years Date stopped smoking:_____________

Alcohol: ☐None ☐Rarely ☐Social 1-2 Drinks/Day ☐Greater than 2 drinks/day ☐Greater than 6 drinks/day

Is your alcohol use a concern for you or others? ☐No ☐Yes

Illicit Drug Use: ☐Never ☐Former ☐Current:________________________ Stopped Use Date:_____________

Caffeine Use: ☐None ☐Coffee ☐Tea ☐Soda _________ # cups/day

Education: ☐High School ☐Some College ☐Degree(s)______________________________

Occupation:______________________________

Marital Status: ☐Single ☐Married ____ years ☐Divorced ☐Widowed Spouse's Name:____________________

Number of Children/Ages:______________________________

Special Interest/Hobbies:______________________________

____

Do you have Advanced Directives? ☐Yes ☐No **Power of Attorney for Medical Care?** ____________________

Health History Form

Allergies (If any, please list name of agent and reaction such as rash/hives, swelling) ☐ No Known Drug Allergies

Current Prescription Medication ☐ NONE

Name	Dose	How Often	Reason For Use

Non-Prescription/Herbals/OTC/Vitamins ☐ NONE

Name	Dose	How Often	Reason For Us

PREVENTATIVE SCREENING/IMMUNIZATIONS

Exam/Test (*indicate last date performed*)		Immunizations (indicate last date administered)	
☐Cholesterol (Lipid Panel)	____________	☐Pneumovax (Pneumonia)	____________
☐Glucose (Diabetes)	____________	☐Influenza (Flu)	____________
☐Cardiovascular Disease (EKG)	____________	☐Zostavax (Shingles)	____________
☐Osteoporosis (Bone Density)	____________	☐Tdap (Tetanus/Diphtheria/Pertussis)	____________
☐Prostate Cancer (PSA/DRE)	____________	☐Td (Tetanus/diphtheria)	____________
☐Breast Cancer (Mammogram)	____________	☐Hepatitis B	____________
☐Cervical Cancer (Pap Smear)	____________	☐Hepatitis A	____________
☐Colon Cancer (Colonoscopy)	____________	☐Other: ____________	____________
☐Lung Cancer (Chest Xray)	____________		
☐Abdominal Aorta (AAA)	____________		
☐Carotid Disease (Ultrasound)	____________		
☐Echocardiogram	____________		
☐Other: ____________	____________		

Health History Form

REVIEW OF SYSTEMS Please check any recent or recurring problems:

Constitutional
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weight Gain _____lbs
- ☐ Weight Loss _____lbs
- ☐ Exercise Intolerance

Eyes
- ☐ Dry Eyes
- ☐ Irritation
- ☐ Vision Changes
- ☐ Cataract History

Ears/Nose/Mouth/Throat
- ☐ Ringing in Ears
- ☐ Difficulty Hearing
- ☐ Dizziness/Vertigo
- ☐ Ear Pain
- ☐ Nose/Sinus Issues
- ☐ Snoring
- ☐ Frequent Colds
- ☐ Frequent Infections
- ☐ Frequent Nosebleeds
- ☐ Frequent Sore Throats
- ☐ Hoarseness
- ☐ Bleeding Gums
- ☐ Dry Mouth
- ☐ Mouth Breathing
- ☐ Mouth Ulcers

Respiratory
- ☐ Cough
- ☐ Coughing up Blood
- ☐ Shortness of Breath
- ☐ Pain with Breathing
- ☐ Wheezing
- ☐ Snoring
- ☐ Sleep Apnea

Cardiovascular
- ☐ Arm Pain with Exertion
- ☐ Chest Pain with Exertion
- ☐ Chest Heaviness
- ☐ Irregular Heart Beats
- ☐ Known Heart Murmur
- ☐ Lightheaded on Standing
- ☐ Shortness of Breath w/ Exertion
- ☐ Swelling (Edema)

Hematologic/Lymphatic
- ☐ Easy Bruising/Bleeding
- ☐ Swollen Glands
- ☐ Anemia

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Black/Tarry Stool
- ☐ Blood in Stool
- ☐ Change in Appetite
- ☐ Indigestion
- ☐ Heartburn
- ☐ Frequent Belching
- ☐ Hemorrhoids
- ☐ Trouble Swallowing
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting Blood

Genitourinary
- ☐ Blood in Urine
- ☐ Difficulty Urinating
- ☐ Pain with Urination
- ☐ Incomplete Emptying
- ☐ Urinary Loss of Control
- ☐ Urinary Frequency
- ☐ Urinary Hesitancy
- ☐ Post-Void Dribbling
- ☐ Erectile Dysfunction

Musculoskeletal
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Aches
- ☐ Muscle Weakness
- ☐ Fractures
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Use of Assist Device

Neurologic
- ☐ Dizziness/Vertigo
- ☐ Poor Balance
- ☐ Headaches
- ☐ Migraine
- ☐ Memory Loss
- ☐ Numbness
- ☐ Restless Legs
- ☐ Seizures
- ☐ Weakness

Psychiatric
- ☐ Anxiety
- ☐ Stress
- ☐ Panic Attacks
- ☐ Depression
- ☐ Mania
- ☐ Sleep Problems
- ☐ Alcohol Overuse
- ☐ History of Addiction
- ☐ Suicidal Thoughts
- ☐ Do Not Feel Safe

Integumentary (Skin)
- ☐ Change in Mole
- ☐ Dry Skin
- ☐ Eczema
- ☐ Rash
- ☐ Growth/Lesion
- ☐ Itching
- ☐ Jaundice (yellow skin/eye)

Allergic/Immunological
- ☐ Sneezing
- ☐ Hives/Rash
- ☐ Itching
- ☐ Runny Nose
- ☐ Sinus Pressure

Men Only
- ☐ Pain or Lump in Testicle
- ☐ Penis Burning/Itching/Discharge
- ☐ Prostate Disease/Problems
- ☐ Night-Time Urination
- ☐ Sexual Problems/Concerns
- ☐ Low Sex Drive

Women Only
- ☐ Vaginal Itching/Burning/Discharge
- ☐ Night-Time Urination
- ☐ Breast Tenderness/Discharge
- ☐ Breast Lump
- ☐ Ovarian Cysts

Total Pregnancies __________
Births __________
Miscarriages __________
Abortions __________

Age Menses/Period Started _________

Men's Vitality Center®
The Nation's Leader in Men's Health

MEN'S PREVENTATIVE WELLNESS PLAN

Name______________________________ Date___________________________

Preventive Service	Frequency	Last Done
Body Mass Index (BMI)_____ Height _____ Weight ______	Annually	
Blood Pressure _______/________	• Every 2 yrs, if BP </= 120/80 mmHg • Annually, if BP >120-139/80-89 mmHg	
Vision	• Every 3 yrs up to age 40; • Every 2 yrs aged 40+	
Abdominal Aortic Aneurysm	• Once, between the age range of 65-75 and smoked 100+ cigarettes in lifetime	
Cholesterol Testing	• Regularly beginning at age 20 with risk factors	
Diabetes Screening	• With a sustained BP >/= 135/80 mmHg	
Colorectal Cancer Screening	• Annually, Fecal Occult Blood Stool (FOBS); • Every 5 yrs, Sigmoidoscopy with FOBS; • Every 10 yrs, Colonoscopy	
Prostate Exam Screening	• Annual PSA blood work age 40 • Digital Rectal Exam: Consider annually age 50 • Age 40-45 if ^Risk factors	
Sexually Transmitted Diseases (STD's)	• As necessary for those with risk factors	
Depression Screening	• As necessary for those with risk factors	
Alcohol Misuse Screening	• As necessary for those with risk factors	
Immunizations: Pneumococcal (Pneumonia) Influenza (Flu)	• Pneumonia: 1-2 doses up to age 64; • Pneumonia: 1 dose age 65+ • Influenza: Annually	

Your major risk factors:
Family history of ___________________ Obesity______ Diabetes_______
Hypertension______ Fall Risk______ Smoking Use______ Other__________

Recommendations for improvement:
Diet_____ Tobacco Cessation_____Weight Management____ Exercise____ Other_____
Referrals

For Staff Use: *[list handouts, referrals, or other follow-up instructions here]*

Men's Vitality Center®

The Nation's Leader in Men's Health

ALERT TO ALL PATIENTS
NO CALL - NO SHOWING APPOINTMENTS

Hello All Patients,

A new protocol is in effect 01/01/2019 regarding the importance of calling 24 hours in advance to cancel a scheduled appointment and calling prior to your appointment time to notify the office that you will be late to your scheduled appointment. If the appointment is not canceled 24 hours in advance or you no show an appointment there will be a fee of $50. Also, if you are more than 15 minutes late to your appointment there is a late fee of $25 and it is up to the providers discretion if you can still be seen that day or need to be rescheduled to another day. These fees must be paid for prior to scheduling your next appointment. This is to ensure each patient has the availability to schedule an appointment if needed in that time slot. We appreciate your cooperation in advance.

Sincerely,
MVC Staff

Please sign/print your name below stating you understand the new protocol and that you are aware of this new update effective 01/01/2019.

____

Signature Print

Date: ____________ Employee Initial: __________

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