



Echelon Integrative New Patient Registration

Patient Information

Name: _____ Date of Birth: _____
 (First) (Last)

Address: _____
 (Street) (Apt/Ste) (City) (State) (Zip)

Home Phone: _____ Cell Phone: _____

Email: _____

Age: _____ Height: _____ Weight: _____

Occupation: _____ Who referred you? _____

Preferred Pharmacy: _____ Pharmacy Phone: _____

Emergency Contact Information

Name: _____ Relationship to patient: _____
 (First) (Last)

Home Phone: _____ Cell Phone: _____

Release Information

I hereby give permission to the person(s) listed below to receive information about the care of the above named patient.

Name(s): _____ Date: _____

Echelon Integrative reserves the right to charge for any scheduled visits that are:

1. Cancelled with less than 24 hour's notice
2. Are missed without calling to cancel (no show)

Cancellation Fee schedule: Existing patient \$10.00

Patient Signature: _____ Date: _____



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Health Habits and Personal Safety

If you are a **FEMALE**, please circle "Yes" or "No" to the following:

Do you exercise?	Yes	No
If yes, how often?		
If yes, what type of exercise?		

Do you consume alcohol?	Yes	No
Do you use tobacco products?	Yes	No

If you are a **FEMALE**, please circle "Yes" or "No" if you experience any of the following:

Hot flashes	Yes	No
Vaginal dryness	Yes	No
Hair loss	Yes	No
Dry skin	Yes	No
Decreasing sex drive	Yes	No
Daytime sleepiness	Yes	No
Moodiness	Yes	No
Weight gain	Yes	No
Increasing fatigue	Yes	No

Please list any surgeries or hospitalizations you may have had previously:

What was the date of your last breast exam and Pap test? _____

What was the date of your last menstrual cycle? _____



Informed Consent for Testosterone Replacement Therapy

Patient: _____ DOB: _____ Date: _____

Testosterone replacement therapy includes use of products such as: injectable Depo-Testosterone, Testosterone Cypionate, Testosterone pellets, and topical products [patches and gel]. Testosterone replacement is approved for cases of primary hypogonadism as well as hypo-gonadotropic hypogonadism. Other uses may be considered “off label”. The safety and efficacy of testosterone supplementation for off label use is not well established.

Contraindications:

You should not use testosterone if you have any of the following:

- Known hypersensitivity to the drug
- Breast Cancer
- Prostate cancer
- Serious Heart, Liver, Kidney disease
- Women who are or may become pregnant

Potential Risks associated with testosterone use include, but are NOT limited to:

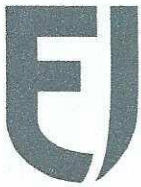
- ~Application/Injection site reaction, Injury to muscle, Blood vessel and/or nerve damage at site,
 - ~Blood clots which could lead to: Heart Attack, Pulmonary embolism, and/or Stroke.,
 - ~Polycythemia, Exacerbation of Congestive Heart Failure or edema, Elevated Cholesterol.
 - ~Elevated Liver enzymes, Hepatitis, Hepatocellular Cancer, Elevated Creatinine levels.
 - ~Enlargement of Prostate, Worsening of Prostate Cancer, Elevated PSA, urinary retention.
 - ~Worsening of Sleep Apnea, Gynecomastia, Elevated Calcium levels.
 - ~Depression, Anxiety, Mood swings, Irritability, Suicidal Ideations.
 - ~Male pattern baldness, Acne, Virilization of women/children if exposed to topical.
- Laboratory testing is REQUIRED prior to and during Testosterone replacement therapy. Regular follow up w provider for management during the course of treatment includes: consultation/discussion and routine labs.

Failure to comply with the required follow up appointments and monitoring, including lab work will result in the termination of therapy.

I have reviewed the risks and side effects that are associated with the use of Testosterone replacement products. I have had the opportunity to have questions answered. I consent to initiating/continuing treatment with Testosterone containing products. I agree to notify the office immediately if I suspect any adverse reactions or side effects from this treatment.

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____



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Notice of Privacy Practices

Federal and State HIPAA laws require that after April 14, 2003, all patients are informed of their medical provider's office privacy practices. We have instituted various safeguards and practices to protect your personal health information and we especially focus on keeping confidential any information that you may consider sensitive. In compliance with the HIPAA laws, we are providing you with a formal notice of our privacy practices. This notice is also posted in our reception area. In the normal process of our daily operations, we do need to disclose some information:

- To remind you of upcoming appointments, we may call and leave a message, e-mail, or text stating the time and date of your appointment.
- We may call, text, or e-mail to inform you of test and lab results.
- For treatment, we may disclose your personal health information to physicians, nurses, and other care personnel who provide you with health care services or are involved in your care.

Please fill out the following information:

I, _____ (Patient), request that all communication to me done by **Chelsey Dobesh NP**, and other staff at Echelon Integrative, be done with the following phone number, address, and e-mail address:

Phone number: _____ Home Cell Other

May we leave a message? Yes No May we text appointment reminders? Yes No

List those people we may leave a message with or speak with concerning your personal health information:

Name: _____ Phone number: _____

Relationship to patient: _____

Name: _____ Phone number: _____

Relationship to patient: _____

I have read this notice and was offered/received (circle one) a copy from the office.

Signature of Patient: _____ Date: _____

Date: _____

ECHELON INTEGRATIVE



Echelon Integrative Credit Card Authorization

Credit Card Authorization Form

Name on card: _____

Type of Card (Circle one): Visa MC AmEx Discover

Card Number: _____

Expiration Date: ____/____ Security Code: _____

Amount to be charged:

Monthly Hormone Treatment: \$ _____

If an appointment is missed: \$ _____

Add-Ons

Add-Ons	
LipoLean	\$40/mo 1x weekly \$60/mo 2x weekly
Phentermine	\$30 per bottle
MK677	\$75 per bottle
Sildenafil (Viagra)	\$50 per bottle
Tadalafil (Cialis)	\$50 per bottle

By signing this form, you authorize Echelon Integrative to charge your card for the amount listed above.

Patient Signature: _____

Date: _____