Balanced Bodie
ANTI-AGING CLINIC

CLIENT MEDICAL HISTORY QUESTIONAIRE

Date_____
_____

Name_____
_____

_____
_____

Name of Primary Care
Physician_____
_____

Date of Last Medical
Exam_____
_____

Past Medical History (Circle all that applies below)

Diabetes/Hypertension/Heart Disease/MI/Cancer/Lung Disease/Stroke/Depression/Sleep Apnea/Enlarged Prostate/Tobacco use: Current/Former

Do you experience any of these symptoms?

Chest pain/Shortness of breath/Swelling to legs/Fainting/Dizziness/constipation/Diarrhea/Difficulty urinating/Blood in urine

Symptoms of Low Testosterone

Decreased sex drive/Decreased energy/Increased body fat/Trouble focusing/Trouble sleeping/Changes in mood/Depression/Decrease lean muscle

List All Medications Including Over the Counter Drugs You Are Taking

List all Medication and Food Allergies

List all Surgeries

Balanced Bodies Anti-Aging Clinic, LLC

Consent for testosterone Replacement/hormone therapy

It is important to understand the practice of medicine is an inexact science. Although our treatment protocols have been created through rigorous research and using the most current scientific evidence, results can vary in their degree of success. It is natural for clients undergoing hormone therapy to want to know everything will be fine. While this is the case in most instances, it is important for you to understand the possible risk and benefits of testosterone replacement therapy.

Our attempt is for you to make an informed decision as to if hormone therapy is appropriate for you. You should also know of the alternatives to testosterone replacement therapy, including not receiving the therapy. If for any reason you are unsure, either consult with your healthcare provider or take some time to weigh your options. We will do our best to answer any questions that you may have. Please review the following information, which discuss informed consent.

This form is designed to document your understanding regarding the benefits and risk of testosterone replacement therapy.

Based on your symptoms and the results of your blood work, Balanced Bodies Anti-Aging Clinic LLC

and its practitioners may have recommended testosterone replacement therapy. Our treatment goal is to optimize your testosterone levels to eliminate or decrease the symptoms of low testosterone and improve overall health and well-being.

Possible complications of not initiating therapy may include worsening of your symptoms as well as those conditions associated with low testosterone and hormone levels. Some of these include heart disease, osteoporosis, depression, sleep disturbances, decreased libido, and premature death.

Potential side effects of testosterone and or replacement therapy include but not limited to overproduction of red blood cells, fluid retention, acne, breast enlargement or sensitivity, hair loss, decreased testosterone or sperm counts, testicle shrinkage, and death. Most of these side effects are reversible with discontinuation of testosterone replacement therapy.

We strive to reduce side effects since we are restoring testosterone levels to a healthy physiologic level using our protocols. Our goal is to optimize testosterone levels to achieve benefits, and to closely monitor levels to prevent side effects and decrease risk.

Initial beside each statement that you have read, understand, and agree with.

____1. This is my consent for Balanced Bodies Anti-Aging Clinic LLC, it's practitioners, nurses, and staff to begin treatment for testosterone and or hormone replacement therapy.

____2. It has been explained to me, and I fully understand, that occasionally there are

complications with testosterone and or replacement therapy such as ache, prostate enlargement, mood swings, breast enlargement, as well as the following (#3-7).

____ 3. Sleep disturbances- this is known as sleep apnea and is most likely seen in patients with lung and heart disease as well individuals who are overweight.

____4. Extra fluid in the body- Can occur in individuals with heart, lung, and kidney problems.

____ 5. Enlargement of prostate- Can cause urinary difficulty.

____ 6. Changes in cholesterol levels, red blood cell levels, PSA levels, liver function enzymes, and other hormone levels which can be monitored with periodical testing.

____ 7. I understand I am required to have periodic blood testing done.

____8. I understand there is no guarantee as to the results of testosterone and or replacement therapy, and if I stop, my condition may return or become worse.

____ 9. I agree to have my personal physician or healthcare provider perform a complete physical exam yearly including a digital rectal exam. If I do not have a personal provider, our practice will assist in finding one for you.

____10. I understand my examination with a Balanced Bodies Anti-Aging Clinic provider does not take the place of a full examination with my personal physician.

____ 11. I have had the opportunity to discuss with Balanced Bodies Anti-Aging Clinic LLC, and its medical practitioners my complete past medical and health history including any serious medical

problems. All my questions regarding risk, benefits, of testosterone replacement therapy, and alternatives have been answered to my satisfaction.

____ 12. INDEMNIFICATION CLAUSE: I agree to indemnify defend, protect, and hold harmless Balanced Bodies Anti-Aging Clinic LLC, partners, employees and those affiliated from, against and in respect of all liabilities, losses, claims, damages, punitive damages, causes of action, lawsuits, administrative proceeding, investigations,, demands, judgements, settlement payments, deficiencies, penalties, fines, interest, and cost and expenses suffered, sustained, incurred, or paid by the indemnified parties in connection with, resulting from or arising out pf, directly or indirectly, Balanced Bodies Anti-Aging Clinic LLC rendering medical care, services, advise, and or treatment, my failure to disclose all relevant medical information regarding my medical and physical condition, acts or omissions of Balanced Bodies Anti-Aging Clinic LLC, harm or injury resulting from medical care or pharmaceuticals directly or indirectly by Balanced Bodies Anti-Aging Clinic LLC. I am aware of the risk and potential side effects with the above described treatment, accept all risk involved in taking medications and will not seek indemnification or damages from the indemnified parties.

____13. I acknowledge, understand, and agree to the terms and conditions disclosed herein, including, but not limited to the indemnification clause for any liabilities, arising out of the testosterone replacement therapy rendered by Balanced Bodies Anti-Aging Clinic, LLC.

Print Name_____

Patient Signature_____

Date_____

Balanced Bodies
ANTI-AGING CLINIC

ACKNOWLEDGEMENT RECEIPT: HIPAA NOTICE OF PRIVACY PRACTICES

In signing this form, you agree that you have received our Notice of Privacy Practices. This Notice, among other points, explains how we plan to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. This applies to the privacy practices of Balanced Bodies Anti-Aging Clinic, LLC. You have the right to review our Notice of Privacy Practices prior to signing this form. It provides details on how we may use and disclose your information. The Notice of Privacy Practices may change periodically. A current copy may be requested from our practice at any time.

By signing this form, you acknowledge you have received our Notice of Privacy Practices and that Balanced Bodies Anti-Aging Clinic, LLC can use and disclose your protected health information in accordance with HIPAA.

Signature of individual or surrogate decision maker:

Date _____

Print Full
Name_____

Signature_____
__

Relationship to patient/legal authority (if applicable)

Date_____

Print Full Name_____

Signature_____
__

Balanced Bodies
ANTI-AGING CLINIC

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.

If you have any questions or concerns please contact immediately: Balanced Bodies Anti-Aging Clinic, LLC 175 Langley Dr Suite E4, Lawrenceville, Ga 30046. Phone number: 470-361-4350

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also

describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

TABLE OF CONTENTS

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart [and in an electronic health record/personal health record].

This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as

our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. [Participants in organized health care arrangements only should add: We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.]

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign in Sheet. We may use and disclose medical information about you by having you sign in when

you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation

which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we

will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide

notification by other methods as appropriate. [Note: Only use e-mail notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example, if your email address is "digestivediseaseassociates.com" an e-mail sent with this address could, if intercepted, identify the patient and their condition.]

22. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

23. Fundraising. We may use or disclose your demographic information in order to contact you for our fundraising activities. For example, we may use the dates that you received treatment, the department of service, your treating physician, outcome information and health insurance status to identify individuals that may be interested in participating in fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices and we will stop any further fundraising communications. Similarly, you should notify the Privacy Officer if you decide you want to start receiving these solicitations again.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which

covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you

or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each

appointment. [For practices with websites add: We will also post the current notice on our website.]

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner this office handles a complaint, you may submit a formal complaint to:

Regional Office for TN/MS/GA: Atlanta Federal Center 61 Forsyth St, Room 5B95 Atlanta, GA 30303-8909 Ph# 404-562-7888 OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf.