Therapy Management Agreement

This agreement by and between the below identified individual ("patient") and Peak Performance Medical, LLC. ("PPM") establishes guidelines and conditions required for the use of hormone replacement therapy ("HRT") involving DEA "controlled" or "scheduled" medications. PPM and patient agree that these guidelines and conditions are an essential factor in maintaining a successful patient / practitioner relationship. Adverse side effects and / or physical / psychological dependence may develop after use of these medications and therefore, these agents are prescribed with caution

The patient agrees and accepts to the following conditions:

1. I understand that the medications I am receiving or will receive are prescribed for me based on diagnoses derived from my submitted medical history, and the results of lab work and a physical examination. The medications are to be used exclusively for treatment of hormonal deficiencies and related medical conditions in accordance with applicable state and federal laws.

2. I understand and agree that no medical treatment or medication provided to me by PPM will be used for the purpose of bodybuilding, performance enhancement or physical appearance.

3. I certify that the answers I provide to the health questions on the Health History form and otherwise to PPM's affiliated physicians'/providers or laboratories are accurate and correct to the best of my knowledge and that I have not been coached by any third party nor have I knowingly been deceptive for secondary gain, for medical treatment or prescription of a medication.

4. I will not attempt to obtain HRT medications from any other health care practitioner without disclosing my current medical usage of HRT or other medications. I understand that it may be against the law to do so.

5. I have discussed and understand the risks and benefits associated with HRT. I will immediately report and adverse side effects related to the use of my HRT to PPM and discontinue use until advised to resume usage by PPM. I voluntarily assume any and all possible risks which may be associated with HRT.

6. I understand that representatives of PPM and / or Licensed Physicians Assistants are available for questions and / or concerning during normal business hours throughout the course of my treatment.

7. I agree that HRT medications furnished by PPM are for my personal use only and for no other purpose. I will not share, sell or trade medications. I will safeguard my medications from loss or theft and will be responsible for their safekeeping.

8. I will be able to purchase the medications from the pharmacy designated by PPM and the pharmacy will send medications directly to me. I understand I have the right to purchase my medications from any pharmacy of my choice. If I choose to obtain medications from a pharmacy of my own choice, I must notify PPM in writing of my intention to do so and include the name of the pharmacy in my request.

9. I agree and understand that federal regulations prohibit the return of prescribed medications.

Patient Initials: ___________

10. I understand that HRT treatment and medications are not covered by health insurance. I agree that all services and medications provided by PPM or its associated providers are to be paid for in advance. I will not seek reimbursement through my health insurance company, Medicare, Medicaid or other third party payer.

11. I agree that the PPM patient / physician relationship is not intended to replace the existing patient / physician relationship with my current primary care provider (PCP) and the treatment provided by PPM will be in conjunction with the care provided by my current PCP.

12. I agree that PPM only treats patients with documented symptoms of hormone deficiencies (Hypogonadism and Adult Growth Hormone Deficiency). No prescription will be provided unless a clinical need exists based on required lab work, physician consolation and current health history through either patient's personal physician or a PPM affiliated physician. Agreement to lab work does not automatically qualify patient to clinically necessity and prescription of HRT.

HAVE SEEN AND AGREED:

Patient Signature: ____ Date: ________________

Printed Name: ____

Medication Management Agreement

This agreement between the below identified individual ("patient") and Peak Performance Medical, LLC. ("PPM") establishes guidelines and conditions required for use of hormone replacement therapy (HRT) involving DEA "controlled" or "scheduled" medications. PPM and patient agree that these guidelines and conditions are an essential factor in maintaining a successful patient / physician relationship. Adverse side effects and / or physical / psychological dependencies may develop after repeated use of these medications and therefore, these agents are prescribed with caution.

The patient accepts and agrees to the following conditions:

1. I understand that the medical treatment offered by PPM and their physician(s) is not accompanied by any claims, guaranteed, promises or warranties.
2. I understand that the medications I have purchased are prescribed for me based on diagnoses derived from my submitted medical history, blood / lab work, and physical examination. They are to be used exclusively for treatment of these diagnoses.
3. I will not attempt to obtain "scheduled" hormone replacement therapy medications illegally or from any other healthcare practitioner without disclosing my current medication usage. I understand that it's against the law to do so.
4. I will immediately report adverse side effects to the use of my medications to PPM and discontinue use until advised to resume usage by PPM.
5. I understand that the PPM Physician (MD), Licensed Nurse Practitioner, and/or Physician Assistants are available for questions and / or concerns during normal business hours throughout the course of my treatment.
6. I will safeguard my medications from loss or theft and will be responsible for their safekeeping.
7. I agree that these medications are for my personal use only and no other purpose and I will not share, sell or trade my medications.
8. I agree that I will use my medications at the prescribed rate and dosage and will keep the medications in its respective labeled container.
9. I agree and understand that federal regulations prohibit the return of prescribed medications.
10. I agree to contact PPM 4-6 weeks into the start of my therapy (and every 6 months thereafter) to arrange for any follow-up blood testing and / or an office visit / consultation as required by the PPM Physician.
11. I understand that to cancel an appointment, I must email or call my cancellation request to my patient care coordinator at least 48 hours prior to my scheduled appointment time or I will be charged a cancelation fee.
12. I agree that the PPM patient / physician relationship is not intended to replace the existing patient / physician relationship with my current primary care provider (PCP) and my PPM treatment will be in conjunction with the care provided by my current PCP.

HAVE SEEN AND AGREED:

Patient Signature: ____ Date: ________________

Printed Name: ____

Waiver

Thank you for your interest in Peak Performance Medical, LLC. ("PPM"). PPM is a company that, among other things, provides Hormone Replacement Therapy ("HRT"). Individuals seek our medical treatments to replace hormones to improve overall health and well-being.

Before we can provide HRT, PPM requires the following:

A. Acceptable results of laboratory tests.
B. Verification of access to primary care physician with whom you have had recent (within the preceding 12 months) physical examination (copy of the physical examination is required).
C. An office visit with a PPM affiliated physician/provider.
D. Completion of all PPM paperwork.

Often individuals who are referred to us have previously received or are currently using medication from other physicians or HRT companies who may or may not follow the same medical evaluation or treatment protocols as we do. In some cases, where inappropriate medications, dosage levels or protocols were provided, an individual's Medical Directors, affiliated physicians and physician extenders take no responsibility and assume no liability for an individual's participation in any prior HRT program. PPM, LLC. Does not use or condone the use of performance enhancement protocols or cyclical hormone therapies.

By signing this waiver you are holding PPM, LLC. (its employees, physicians, agents and associates) harmless for any damages and liability including without limitation, attorneys fees and costs at all levels of trial and appeal related to health issues that are present or may arise in the future from previous (whether disclosed or undisclosed to PPM) HRT therapies, medication or protocols.

I certify that I have not previously received HRT and that I am not currently undergoing and / or receiving HRT.

HAVE SEEN AND AGREED:

Patient Signature: ____ Date: ________________

Printed Name: ____

NEW PATIENT REGISTRATION AND HISTORY

*Please Complete **ENTIRE** Form and Return to Front Desk*
Settlement of Patient Financial Responsibility is Expected at Time of Service

PATIENT INFORMATION:

Last:_____________________________ First:_______________________________ Middle Initial:__________

Date of Birth:____________________ Social Security Number:______________________ Sex: ☐M ☐ F

Phone:____________________________________ Email Address:____________________________________

Address:____

City:____ State:_____________ Zip Code___________

May we leave a message regarding your care (x-ray, lab results) on your phone: ☐Yes ☐No

May we send electronic messages to your email address on file: ☐Yes ☐No

Would you like to receive text reminders of upcoming appointments: ☐Yes ☐No

Parent or Legal Guardian name (if applicable):___________________________ Relationship:______________

Emergency Contact:____ Relationship:______________

Phone:____________________________________ Email Address:____________________________________

Address (if different): ____

City:____ State:_____________ Zip Code___________

Acknowledgements:

HIPAA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgment Form (§164.520(a): I understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been given an opportunity to review and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I further understand that this facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested

FINANCIAL AGREEMENT: I understand that I am financially responsible and agree to pay all of the charges associated with my care. I understand that I am responsible for payment at the time the service is provided and, if required agree to enter into a separate financial contract.

CONSENTS, DISCLOSURES AND ACKNOWLEDGMENTS: I voluntarily consent to treatment for myself and/or my dependents. I acknowledge that I have been advised of my right to receive copies of any documents and records which Peak Performance Medical, LLC. has in its possession for myself and/or my dependent.

RELEASE OF INFORMATION: I authorize the facility to release (verbally or in writing) confidential medical information to any person or entity which may be liable to me or my Practitioner(s) for charges for this treatment, and for quality management, utilization review, transfer, and follow-up purposes. I understand that a copy of this agreement may be used with the same effectiveness as an original.

Signature of Patient:____________________________________ Date:___________________

MEDICAL HISTORY

All Information Obtained Will be Kept in Accordance With Applicable HIPAA Privacy Standards

Name: (Last, First, Mi) ____ ☐M ☐F D.O.B: __________

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

Previous/Referring Physician: ___________________________________ Date of Last Exam: ____________

PERSONAL HEALTH HISTORY

Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and Dates (if known):

☐ Tetanus _______
☐ Hepatitis _______
☐ Influenza _______
☐ Pneumonia ________
☐ Chickenpox ________
☐ MMR ________ (measles, mumps, rubella)

List any Medical Problems That Other Doctors Have Diagnosed:

1.____ 3. ____
2.____ 4.____

Surgeries:

Year Reason Hospital

_______ ____ ____
_______ ____ ____
_______ ____ ____

Other Hospitalizations:

Year Reason Hospital

_______ ____ ____
_______ ____ ____
_______ ____ ____

Have You Ever had a Blood Transfusion? ☐ Yes ☐ No **If so Appro'x Date of Last Transfusion:**__________

Are you Allergic to any Medications? If so, Please List Allergic Reaction:

Medication Reaction

____ ____
____ ____
____ ____

Are you Allergic to Latex: ☐ Yes ☐ No?

Do you Have Any Other Allergies? If yes, Please explain:____
____

Please list any medications you are currently taking, along with dosage and frequency (including non-prescription medications, vitamins, herbs, or supplements.):

Name	Dosage	Frequency

Family History:

	Age	Significant Health Problems		Age	Significant Health Problem
Father			Children		
Mother			☐M ☐F		
Siblings			☐M ☐F		
☐M ☐F			☐M ☐F		
☐M ☐F			Grandmother (paternal)		
☐M ☐F			Grandfather (paternal)		
☐M ☐F			Grandfather (maternal)		
☐M ☐F			Grandmother(maternal)		

Mental Health:

	YES	NO
1. Is Stress a Major Problem for You?	☐	☐
2. Do You Feel Depressed?	☐	☐
3. Do You Panic When Stressed?	☐	☐
4. Do You Have Problems With Eating or Your Appetite?	☐	☐
5. Do You Cry Frequently?	☐	☐
6. Have You Ever Attempted Suicide?	☐	☐
7. Have You Ever Seriously Thought About Hurting Yourself?	☐	☐
8. Do You Have Trouble Sleeping?	☐	☐
9. Have You Ever Been to a Counselor?	☐	☐

Men Only:

	YES	NO
1. Do You Usually Get Up to Urinate Through the Night?	☐	☐
If Yes, How Many Times? _____		
2. Do You feel Pain or Burning When Urinating?	☐	☐
3. Any Blood in Your Urine?	☐	☐
4. Do You Feel Burning Discharge From Penis?	☐	☐
5. Has the Force of your Urination Deceased?	☐	☐
6. Have You Had Any Kidney, Bladder or Prostate Infections within the last 12 Months?	☐	☐
7. Do You Have Any Problems Emptying Your Bladder Completely?	☐	☐
8. Any Difficulty with Erection or Ejaculation?	☐	☐
9. Any Testicle Pain or Swelling?	☐	☐
10. Date of Last Prostate Exam ____________ Rectal Exam ______________		

Women Only:

	YES	NO
1. Age at Onset of Menstruation ________		
2. Date of Last Menstruation ________ Period Every _____ Days		
4. Heavy Periods, Irregularity, Spotting, pain or Discharge	☐	☐
5. Number of Pregnancies _____ Number of Live Births _____		
6. Are You Pregnant or Nursing?	☐	☐
7. Have You Had a D&C, Hysterectomy or Cesarean?	☐	☐
8. Any Urinary tract, Bladder or Kidney Infections Within the Last Year?	☐	☐
9. Any Blood in Your Urine?	☐	☐
10. Any Problem With Control of Urination?	☐	☐
11. Any Hot Flashes or Sweating at Night?	☐	☐
12. Do You Have Menstrual Tension, Pain, Bloating, Irritability at the Time of Period?	☐	☐
13. Experienced Any Recent Breast Tenderness, Lumps or Nipple Discharge?	☐	☐
14. Date of Last Pap Exam ___________ Rectal Exam _____________	☐	☐

Other Conditions/Discomforts (please check and briefly explain any conditions/discomforts affecting the following)

☐ Skin____	☐ Bladder______________________________________
☐ Head/Neck___________________________________	☐ Chest / Heart _________________________________
☐ Ears ____	☐ Circulation ___________________________________
☐ Nose _______________________________________	Recent Changes in:
☐ Throat ______________________________________	☐ Weight _____________________________________
☐ Lungs _______________________________________	☐ Energy Level_________________________________
	☐ Ability to Sleep ______________________________

Is There Anything Else About Your Physical and/or Mental Health That you Feel Our Providers Should Know?

If Yes, Please Explain:____

____

____

____

The Information Contained in This Medical History Form, is to the Best of my Reasonable Information and Belief, True Correct and Accurate

Signature of Patient:_____________________________________ Date:___________________