MEN'S HEALTH ALASKA

3851 Piper St Suite: U431
Anchorage, AK 99508
Phone: 907-215-6709
Fax: 855-259-0324

Patient Information:

Name: _____ DOB: _____

SSN: _____-____-_____ Gender: _____ Marital Status_____

Race: _____ Ethnicity: _____ Preferred Language: _____

Mailing Address: _____

Home Address: _____

Phone Number: _____-_____-_____ □ Mobile □ Home □ Work □ Other

E-mail Address: _____

Employer: _____ Employer Phone Number: _____-_____-_____

Referring Provider Office: _____ Contact Number: _____-_____-_____

Primary Care Provider: _____ Contact Number: _____-_____-_____

Emergency Contact: _____ Relationship:_____

Emergency Contact number _____-_____-_____

You may authorize us to release protected health information to the following individuals and select from the options listed below. You can revoke this access at any time:

Name: _____ DOB: _____ Relation: _____

□ Appointments □ Diagnosis □ Treatment □ Billing

Name: _____ DOB: _____ Relation: _____

□ Appointments □ Diagnosis □ Treatment □ Billing

Insurance Information:

Primary Insurance: _____ Secondary Insurance: _____

Policy Holder Name: _____ Policy Holder Name: _____

Policy/Member Number: _____ Policy/Member Number: _____

DOB: _____ SSN: _____-____-_____ DOB: _____ SSN: _____-____-_____

Relation to Patient: _____ Relation to Patient: _____

Patient/Guardian Signature: _____ Date: _____

Representative Initials: _____

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose your protected health information.

This notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of this notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1196) law allows for the use of your information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information in accordance with federal guidelines and for anonymous usage in potential publications. You have the right to revoke this consent in writing by supplying written documentation of intent to revoke with your signature. However, such a revocation will not be retroactive.

By signing this form, you understand and acknowledge the following

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosure will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email or send a text to you to confirm appointments? □ **Yes** □ **No**

May we leave a voice message at home or on your cell phone? □ **Yes** □ **No**

This consent was signed by: _____

PRINT NAME ABOVE

Signature: _____ Date: _____

Witness: _____ Date: _____

Representative Initials: _____

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Patient Financial Policy

Thank you for choosing Men's Health Alaska as your healthcare provider. We are committed to providing you with quality care. Your clear understanding of our Patient Financial Policy is important to our professional relationship. If you have any questions about our fees, our policies, or your financial responsibilities, please do not hesitate to ask our office staff or contact our billing department. Please take time to carefully review the following information and return this form to the front desk with your signature and today's date.

We require that all patients complete our Patient Financial Policy prior to seeing the physician. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc.).

Insurance

Initials:	
_____	It is the patient's responsibility to provide our office with current insurance. We will ask for and copy your insurance at your first visit. Please bring your current insurance card to each visit. We will ask to verify the card.
_____	If current information is not obtained at the time of service, it will become the patient's responsibility to pay the entire balance until current information is provided to our office.
_____	Your insurance policy is a contract between you and your insurance company. As a courtesy, and pursuant to contractual obligations, we file all claims for you. We supply information as necessary.
_____	You are ultimately responsible for the timely payment of your account.

Co-Pays

Co-payments are due at the time you check out from your appointment.

Deductibles and Coinsurance for hospital/in-office procedures

Balances related to unmet deductibles and/or co-insurance, as per the health coverage plan you have with your insurance, will be due after the insurance has processed your claim.

Outstanding Balances – (Collection Agency/Bankruptcy)

Payments are to be made in a timely manner unless payment arrangements have been made and are on file with our Practice Manager. Many options are available that can alleviate the financial stress of medical costs. Any overdue balances may be processed to a collection agency for additional collection efforts. If the account is referred to a collection agency, this may result in discharge from the practice and/or the inability to schedule an appointment.

All balances not paid by your insurance carrier will be billed to you. Questions about how your claim was processed are to be directed to your insurance carrier or to our Practice Manager.

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Returned Checks (FEE APPLIED):

The charge for a returned check is $50.00 payable by cash, money order or charge (no checks accepted). This will be applied to your account in addition to the insufficient funds amount.

Missed Appointments (FEE APPLIED):

Please help us serve you better by keeping scheduled appointments. In the event you are unable to keep your appointment we request, at minimum, a **24-hour notice**. Failure to provide notice will result in a **$50.00** missed appointment charge for all consultation and follow-up appointments. Failure to provide notice for a procedure in office will result in a **$100.00** fee. These charges are the responsibility of the patient and are not covered by any insurance carrier and must be paid before rescheduling.

A missed appointment is considered:

1. Failure to show up for a scheduled appointment.
2. Canceling an appointment without giving 24 hours' notice.
3. Showing up more than 15 minutes late for an appointment.

CREDIT BALANCES:

If your account reflects a balance of **$5.00 or less,** our policy for collection is to carry over the balance on the account until your next appointment or in the event that you transfer care from the organization. If your account reflects a credit balance of **more than $5.00,** our policy is that we will maintain your credit until our Accounts Receivable staff processes your credit or a request is made by you, the patient, to receive a refund. All refunds are reviewed and processed every 30 days, if you made a request please allow ample time for review of your entire account and processing through our accounting department. Refunds are not issued when outstanding insurance claims are still 'in processing' with your insurance company. Please call us with any questions if this should occur. Like all businesses it is our intention to thoroughly explain our financial policies and set forth our expectations. Your assistance and cooperation are appreciated. We are pleased to have the opportunity to meet your health care needs and encourage you to contact our billing department with any questions or concerns.

I have read the Patient Financial Policy and acknowledge my responsibilities by affixing my signature below.

Patient Printed Name: _____ DOB: _____

Patient/Responsible Party Signature: _____ Date: _____

Representative Initials: _____

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Name: _____ **Date:** _____

Briefly explain reason for visit: _____

Where did you hear about us? _____

Primary Care provider name and location: _____

Preferred Pharmacy: _____ City: _____ Cross Street: _____

Current Medications and Supplements

Medication	Dosage	Duration

Allergies

Allergens	Reactions

Past Medical History:

Conditions/Previous Illness	Duration

Surgical History

Procedure	Date	Location

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Hospitalization History

Reason for Admission	Date	Location

Family History

Relation	Age	Living	Serious Illnesses/Medical Conditions/Cause of Death
Mother		Y / N	
Father		Y / N	
Siblings		Y / N	

Social History:

Tobacco Use: Indicate below all that apply

□ Not applicable □ Former □ Current

Year started: _____ Year started: _____

Year quit: _____ Pack per day: _____

Previous pack per day: _____ Interested in quitting: Y / N

Alcohol Use: Indicate all that apply

□ Never □ Occasional (less than 4 times a month) □ Current (some days) □ Current (every day)

# of drinks per week: _____ # per day: _____

Marijuana Use:

□ Never □ Occasional □ Routine

Frequency per week: _____ Frequency per day: _____

Illicit Drug Use:

□ Never □ Occasional □ Routine

Frequency per week: _____ Frequency per day: _____

Patient/Guardian Signature: _____ Date: _____

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Review of Systems

Circle all that apply

General: Chills Fever Headache Weight Loss

ENT: Difficulty Swallowing Nose/Throat Problems Snores Sore Throat

Respiratory: Breathing Problems Chest Pain Blood When Coughs Shortness of Breath Wheezing

Cardiovascular: Chest Pain Pain in Calves Dizziness Painful Breathing with exertion

Gastrointestinal: Abdominal Pain Blood in Stool Constipation Diarrhea Heartburn Vomiting

Hematology: Bleeding Problems Easy Bruising Anemia

Genitourinary: Urinary Urgency Incontinence Blood in Urine Difficulty Urinating Frequent Urination Kidney Problems Painful Urination

Musculoskeletal: Arthritis Back Problems Joint Stiffness Weakness

Skin: Acne Dry Skin Eczema

Neurologic: Memory Loss Seizures Numbness/Tingling

Psychiatric: Anxiety Depressed mood Difficulty Sleeping Substance abuse

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International Prostate Symptom Score (I-PSS)							
In the past month:	**Not at All**	**Less than 1 in 5 times**	**Less than Half the Time**	**About Half the Time**	**More than Half the Time**	**Almost Always**	**Your Score**
1. Incomplete Emptying How often have you had the sensation of not emptying your bladder?	0	1	2	3	4	5	
2. **Frequency** How often have you had to urinate less than every two hours?	0	1	2	3	4	5	
3. Intermittency How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
4. Urgency How often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Weak Stream How often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Straining How often have you had to strain to start urination?	0	1	2	3	4	5	
	None	**1 time**	**2 times**	**3 times**	**4 times**	**5 times**	
7. Nocturia How many times did you typically get up at night to urinate?	0	1	2	3	4	5	
Total I-PSS Score							
Score:	1-7 Mild		8-19 Moderate		20-35 Severe		
		The first seven questions of the I-PSS are from the American Urological Association (AUA) Symptom Index					
Quality of Life Due to Urinary Symptoms							
	Delighted	**Pleased**	**Mostly Satisfied**	**Mixed**	**Mostly Dissatisfied**	**Unhappy**	**Terrible**
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	**0**	**1**	**2**	**3**	**4**	**5**	**6**

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The IIEF-5 Questionnaire (SHIM)

Please encircle the response that best describes you for the following five questions:

- **Sexual activity includes intercourse, caressing, foreplay and masturbation**
- **Sexual intercourse is defined as vaginal penetration of the partner (you entered the partner**
- **Sexual stimulation includes situations like foreplay with a partner, looking at erotic pictures, etc**
- **Ejaculate is defined as the ejection of semen from the penis (or the feeling of this)**

Over the past 6 months:					
1. How do you rate your confidence that you could get and keep an erection?	Very low 1	Low 2	Moderate 3	High 4	Very high 5
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration?	Almost never or never 1	A few times (much less than half the time) 2	Sometimes (about half the time) 3	Most times (much more than half the time) 4	Almost always or always 5
3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated your partner?	Almost never of never 1	A few times (much less than half the time) 2	Sometimes (about half the time) 3	Most times (much more than half the time) 4	Almost always or always 5
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	Extremely difficult 1	Very difficult 2	Difficult 3	Slightly difficult 4	Not difficult 5
5. When you attempted sexual intercourse, how often was it satisfactory for you?	Almost never or never 1	A few times (much less than half the time) 2	Sometimes (about half the time) 3	Most times (much more than half the time) 4	Almost always or always 5

Total Score: _____

1-7: Severe ED 8-11: Moderate ED 12-16: Mild-moderate ED 17-21: Mild ED 22-25: No ED

Representative Initials: _____