Eagle's Landing Longevity Center

-Registration Form-& Acknowledgements

(please print)

Date _____/_____/_____

-Patient Information-

Name _____ SS # _____-_____-_____
Last Name First Name Middle Initial

Home Phone:_____-_____-_____ Cell Phone:_____-_____-_____

Address _____City _____State_____ Zip _____

Sex: M___ F___ Age_____ Birthdate _____/_____/_____ Married ___ Widowed ___ Single ___ Minor ___
Separated ___ Divorced ___ Partnered for ____ years

Email:_____

Patient Employer/School _____ Occupation _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone:_____-_____-_____

Pharmacy Name: _____ Phone Number:_____-_____-_____

-Primary Insurance-See Card

-Additional Insurance-See Card

-Assignment and Release-

I certify that I, and/or my dependent(s), have insurance coverage with _____and assign
Name of Insurance Company
directly to Eagle's Landing Longevity Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
Eagle's Landing Longevity Center may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____/_____/_____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Parent, Guardian or Personal Representative Relationship to Patient

Privacy Practices

I _____, certify that I have read and understand Eagle's Landing Longevity Center Privacy Practices.

_____ _____/_____/_____
Patient or Legal Authorized Signature Date
Relation to patient if anyone other than patient:_____

Financial Policy

My signature below indicates that I have read, understand and accept full responsibility for the balance on my account for any services provided by Eagle's Landing Longevity Center.

Signature:_____ Date:_____/_____/_____

Print Name:_____ SS:_____-_____-_____

Eagle's Landing Longevity Center

Privacy Practices

I understand that Eagle's Landing Longevity Center may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other healthcare operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.

Eagle's Landing Longevity Center has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting a patient's privacy. I understand I have the right to read the Notice of Privacy Practices before signing this acknowledgement.

Eagle's Landing Longevity Center may update this Acknowledgement and Notice of Privacy Practices. If I ask, Eagle's Landing Longevity Center will provide me with the most current Notice of Privacy Practices.

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but are not limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative location.

Eagle's Landing Longevity Center has established procedures that help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgements, and authorizations; reasonable time frames for requesting information; charges for copies of non-routine information needs; etc. I will assist by following these procedures if I choose to exercise any of my rights described in the Notice of privacy Practices.

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Eagle's Landing Longevity Center

Financial Policy

Thank you for selecting Eagle's Landing Longevity Center for your healthcare needs. In order to prevent any misunderstanding concerning the responsibility of payment for medical care and laboratory fees, the following information is provided.

HMO / PPO / Other Insurance Coverage

All co-payments are collected prior to the office visit. Failure to provide all necessary information may result in the patient's responsibility to pay for services in full on the date of the office visit or laboratory service. Patients will be financially responsible for all co-payments, deductibles, co-insurance, non-covered services, and other amounts identified by the insurance company as due from patient.

Medicare

Eagle's Landing Longevity Center accepts Medicare assignment. Patients are responsible for the deductible, 20% coinsurance, and all noncovered services. If you have secondary insurance, please provide us with that information so that we can submit a claim on your behalf. Please keep in mind that Medicare does not cover preventive care. You will be responsible for annual exams and other preventive services.

Laboratory

Depending on your insurance plan, you may be responsible to pay an additional co-payment for specimen taken during your office visit.

Self-Pay Patients

Patients without health insurance and patients who do not wish for Eagle's Landing Longevity Center to bill their insurance company are required to pay for the services in full on the date of service.

Payments

Payments can be made by cash, check, Care Credit, Visa, Master Card, and Discover. Prepaid Debit/Gift cards are **not acceptable** methods of payment.

Returned Checks and Collections

A charge of **$25** will be added to a patient's account for all refunded checks. In the event that any action is brought to collection, patient is required to pay any reasonable collection costs and/or attorney fees. Patients can face possible dismissal from the practice for any unpaid balance/collection history. A **$35** fee will be applied to all accounts sent to collections.

No Show / Missed Appointments

A Charge of **$50.00** will be added to patient's account when they do not show up for a scheduled appointment or fail to give a minimum 24 -hour cancellation notice. A charge of **$125.00** will be added to patient's account when they fail to show up for a scheduled **Ultrasound or Diagnostic Studies** appointment or fail to give a minimum 24- hour cancellation notice. Any patient who has multiple missed appointments or who repeatedly does not give proper cancellation notice may be dismissed from the practice.

Insurance Disclaimer: "A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service."

Insurance Liability for Payment: Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures preauthorized by your health insurance company. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service.

Beneficiary Agreement: I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

Eagle's Landing Longevity Center

Medical Information Authorization

Patient Name:_____ Date of Birth:____/____/____

Print first and last name

I authorize Eagle's Landing Longevity Center to release my medical information to any of the following listed below:

	Name	Relationship to patient	Phone numbers
1.	_____	_____	____-____-____
2.	_____	_____	____-____-____
3.	_____	_____	____-____-____
4.	_____	_____	____-____-____

I may revoke this authorization by phone or in writing at any time.

Permission to leave a message on a voicemail ____Yes ____No

Patient Signature:_____ Date:____/____/____

Witness Signature:_____ Date:____/____/____

Eagle's Landing Longevity Center

Medical History Form

NAME:_____ DATE:_____

DOB:_____AGE:_____WEIGHT:_____ HEIGHT:_____OCCUPATION:_____

Reason for office visit: Date Began:

_____ _____

_____ _____

Drug Allergies

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Transfusions – Date (year) _____ Most Recent: _____

Father's Age and Health _____

Mother's Age and Health _____

Brothers/Sisters Age and Health _____

Children _____

Any Family History {blood relative} who has had:

Diabetes _____

Elevated Blood Pressure _____

Heart Disease _____

Cancer _____

Do you smoke?	Yes or No	How Much?_____
Do you drink alcohol?	Yes or No	How Much?_____
Do you drink tea?	Yes or No	How Much?_____
Do you drink coffee?	Yes or No	How Much?_____

Date of last physical exam:_____ Practitioner name and phone number_____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis): _____

_____

Outcome:_____

List current health problems for which you are being treated _____, _____, _____

_____ _____ ,_____, _____

Current Medications (prescription or over-the-counter)_____, _____, _____, _____

_____, _____, _____, _____, _____

Major hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
____	_____	_____
____	_____	_____

Do you experience any of these general symptoms EVERY DAY? (please circle)

Debilitating Fatigue Shortness of Breath Insomnia Constipation Chronic Pain/Inflammation Depression Panic Attacks Nausea Fecal Incontinence Bleeding Disinterest in sex Headaches Vomiting Urinary Incontinence Discharge Disinterest in eating Disinterest in eating Dizziness Diarrhea Low grade fever Itching

BHRT CHECKLIST FOR WOMEN

Name: _____ **Date:** _____

E-Mail: _____ **DOB** _____ **Age:** _____

Symptom *(please check mark)*	Never	Mild	Moderate	Severe
Depressive mood (feeling down/sad/lack of drive)				
Memory Loss (forgetfulness)				
Mental confusion (feeling in a mental fog)				
Decreased sex drive/libido (decreased desire for sex)				
Sleep problems (difficulty falling/staying asleep/wake up tired)				
Mood changes/Irritability				
Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and Wrinkled Skin				
Hair is Falling Out				
Cold all the time				
Swelling all over the body				
Joint pain				

Family History: *Circle all that Apply*

Heart Disease Diabetes Osteoporosis Alzheimers Disease Breast Cancer

Medical History: *Circle all that apply*

On Birth Control _____ Still Menstrating Experiencing Symptons Currently Pregnant

On HRT (Type/Dose)_____ Hashimoto's

Currently of Thyroid Medication (Type/Dose) _____ History of Breast Cancer

Hysterectomy Fibrocystic Breast Disease PCOS

History of Uterine Fibroids or Endometria Polys Smoker

Symptons: *Circle all that apply*

Acne Breast Tenderness

Facial Hair PreMenstrual Migraines **Weight:** _____ **Ethnicity:** _____

BHRT CHECKLIST FOR MEN

BHRT CHECKLIST FOR MEN **Date:**

E-mail: **DOB:** **Age:**

Symptom ***(please check mark)***	**Never**	**Mild**	**Moderate**	**Severe**
Decline in general well being (General state of health)				
Joint pain/muscle ache (Lower back/joint/limb pain)				
Excessive sweating (Sudden episodes/hot flash)				
Sleep problems (Difficulty falling/staying asleep/wake up tired)				
Increased need for sleep (Feel tired often)				
Irritability (Aggressive/easily upset/moody)				
Nervousness (Inner tension/restlessness)				
Anxiety (Feeling panicky)				
Depressed mood (Feeling down/sad/lack of drive/nothing of any use)				
Exhaustion/lacking vitality (Decreased performance & activity/lack of interest/motivation)				
Declining Mental Ability/Focus/Concentration				
Feeling you have passed your peak				
Feeling burned out/hit rock bottom				
Decreased muscle strength				
Weight Gain/Belly Fat/Inability to Lose Weight				
Breast Development				
Shrinking Testicles				
Rapid Hair Loss				
Decrease in beard growth				
New Migraine Headaches				
Decreased desire/libido				
Decreased morning erections				
Decreased ability to perform sexually				
Infrequent or Absent Ejaculations				
No Results from E.D. Medications				

Family History: *Circle all that Apply*

Heart Disease Diabetes Osteoporosis Alzheimers Disease

Medical History: *Circle all that Apply*

Altitude (above 5,000 ft) Hashimoto's Prostate Cancer _____ On 5a Reductase

Urological WorkUp Performed & OK Currently on Thyroid Medication (Type/Dose) _____

Activity Level: Low Moderate Medium High High **Weight:** _____ **Ethnicity:** _____

Allergy Questionnaire

Patient Name:_____ DOB:_____/_____/_____

Phone Number:_____-_____-_____ Date:_____/_____/_____

Do you experience any of the following symptoms?			Frequency Daily, Weekly, Monthly, Seasonally, Year round
	Yes	No	
Runny/Stuffy nose, Frequent Sneezing,			
Post nasal drip			
Itchy/Dry/Watery eyes			
Itchy/Dry mouth, throat, or ears			
Frequent cough or Frequent colds			
Seasonal allergies			
Sinus problems			
Food allergies			
Restless, Poor sleep or snoring			
Fatigue or irritability due to restlessness or			
Poor sleep			
Have you ever been told you have Asthma, RAD or			
Eczema?			
Have you ever used Albuterol?			
Have you ever been to an Allergist?			
Does your family have a history of Allergies?			
Do you think you might be allergic to animals?			

What medicines have you used to control your symptoms in the past year? (Please check)

Over-The-Counter Medications

a. Allergy/Cold Medications
____ Claritin, Alavert, Zyrtec or Allegra
____ Benedryl or Sudafed
____ Cough, Cold or Sinus Medication

b. Over-The-Counter Nasal Sprays
____ Nasal Saline, Nasal Washes or Neti-Pot

c. Over-The-Counter Nasal Decongestants allergies
____ Afrin or Neosynephrine

Prescription Medicines

d. Oral Allergy Medications
____ Claritin, Zyzol, Singular

e. Nasal Steroids/Antihistamines
____ Flonase, Nasonex, Rhinocort, Nasacort
Astelin, Veramyst, Pantanase

Have you been previously tested for allergies
___Yes ___No

List any allergy medications you have tried_____

Above information reviewed and discussed with the patient ____ Yes ____No
I will refer this patient out for In-House Allergy testing ____Yes ____No

Provider:_____

Eagle's Landing
LONGEVITY CENTER
Internal Medicine & Aesthetics

VEIN HISTORY FORM

Name: _____ Date: _____

DOB: _____ Age: ____ Gender: ☐ M ☐ F

Referred by a Physician? □ Yes □ No

Occupation (please provide a brief description of job duties; standing, walking, sitting):

_____

_____

If yes, Whom: _____

Specialty: _____

What made you decide to seek treatment at this time? _____

Symptoms (check all that applies)

Aching/Pain in leg	Left □	Right □
Heaviness	Left □	Right □
Tiredness/Fatigue	Left □	Right □
Itching/Burning	Left □	Right □
Swelling	Left □	Right □
Leg Cramps	Left □	Right □
Throbbing	Left □	Right □

Comments: _____

_____

_____

If you answered Yes to any of the questions above:

1. How long have you been experiencing these symptoms? _____
2. Are you taking pain medication (prescribed/over the counter)? For how long?

   _____

   _____
3. Do you now or have you ever worn prescription compression hose? Duration? For how long?

   _____

   _____
4. Do these symptoms affect your daily functioning? If so, how?

   _____

   _____

   _____

   _____

   _____

Check all that applies

___ My veins have deteriorated in recent months.
___ I elevate my legs to relieve discomfort
___ I wear support hose.
___ They help reduce my symptoms
___ I smoke ____ packs per day.

For Women Only:

___ My symptoms worsen before or during menstruation.
___ I am pregnant or actively trying to get pregnant.
___ I am currently breastfeeding.
___ Pregnancies ___ Deliveries

Patient History

___ Leg Ulcer ___ Heart Disease
___ Diabetes ___ HIV (AIDS)
___Blood Clots (Phlebitis) ___ Other _____

___ Previous Vein Evaluation Date: _____
___ Previous Vein Surgery
Type: _____ Date: _____

Family History

___ Varicose Veins ___ Leg Ulcers
___ Heart Disease ___ Diabetes
___ Vascular Disease