6213 Colleyville Blvd., Ste. 150
Colleyville, TX 76034
Phone 817.812.3044
Fax 682.223.1135

New Adult Male History Patient Form

To our new patients: _Welcome_ to the Medical practice of **Dr. Scott D. Lauer**. To help us establish you with our practice, please provide us with your complete health history:

Date: ________________ Home Phone: _____________________Age:___________

Name:
____
Last First Middle Maiden

Address: ____Birth date: ____________
City: __________________ ST: ___ Zip Code: __________ SS#:______-____-______
Marital Status: ______________ Occupation: _________________________________
Employed By: ________________________ Work Phone: ______________________
Email Address:___________________________________
Referred by; ____
Please list any medication allergies: ____
Last exam date _________________ Doctor____________________________________

Person to call if unable to reach you:

Name: ______________________________ Relationship: ______________________
Address: ___________________________________ Phone: ____________________

If you have Insurance please complete:

Name of Insurance Company: ____
Address of Insurance Company: ____
Insured ID Number: ____
Group Number: _______________________ Phone Number: ____________________

HISTORY QUESTIONNAIRE (CIRCLE YES OR NO)

YES NO Have you had any muscle weakness, fatigue or loss of muscle mass?
YES NO Has your interest in sex (libido) declined?
YES NO Do you have spontaneous erections (without medication or other aid)?
YES NO Has your energy level or stamina declined?
YES NO Have you lost self confidence, motivation, or initiative?
YES NO Has there been any decline in memory or concentration ability?
YES NO Have you had any sleep disturbance or problem breathing while asleep?
YES NO Do you have mood swings or depression?
YES NO Have you notice any increase in aggressiveness?
YES NO Do you have any breast tenderness or enlargement?
YES NO Have you lost any hair in the genital or underarm areas?
YES NO Has your need to shave decreased?
YES NO Have you noticed any significant change in size of your testicles?
YES NO Do you have periodic hot flashes or sweats?
YES NO Have you ever had problems achieving a pregnancy?
YES NO Are you considering have any (or more) children?

PAST HISTORY:

YES NO Have you ever had an abnormal PSA test?
YES NO Do you have or have you ever had thyroid disease, diabetes, high blood pressure, asthma/ lung disease, acne, dry or oily skin, or any venereal disease?
YES NO Do you have allergies to any medications? If yes, please list below.

YES NO Do you take any medications on a daily basis? If yes, please list below

YES NO Have you ever had any surgery in the prostate or genital area? If yes, please list below.

FAMILY HISTORY:

YES NO Do you have any blood related family with prostate cancer?
YES NO Do you have any blood related family with diabetes?
YES NO Do you have any blood related family with cardiovascular disease?

SOCIAL HISTORY:

YES NO Do you smoke? If yes, how much? ____________
YES NO Do you drink alcoholic beverages? If yes, how much?______________

______________________________ ______________

Patient signature **Date**

REVIEWS OF SYSTEMS: Please check all that applies:

Weight loss or gain Fever or chills Trouble sleeping Fatigue/Weakness

Skin:
- Rashes Itching Color changes Lump

Head:
- Headache Head injury

Ears:
- Decreased hearing EaracheRinging in ears (tinnitus) Drainage

Eyes:
- Eye Pain Redness Blurry or double vision Cataracts Glaucoma

Nose:
- Stuffiness Itching Nosebleeds Discharge Hay fever Sinus pain

Throat:
- Teeth Gums Bleeding Dentures

Respiratory:
- Cough (dry or wet, productive) Sputum (color and amount)
- Coughing up blood Wheezing (hemoptysis) Painful breathing

Cardiovascular:
- Chest pain Tightness Palpitations Shortness of breath w/ activity
  Swelling in legs

Gastrointestinal:
- Constipation Diarrhea Changes in bowel habits

Urinary:
- Weak stream or trouble starting stream Urgency Weak stream
  History of enlarged prostate Get up multiple times at night to urinate

Genital- Male:
- Pain with sex Hernia Change in urinary (hematuria)
  Incontinence Masses or pain Erectile dysfunction
  Loss or change in libido

Vascular:
- Calf pain with walking Leg cramping

Musculoskeletal:
- Muscle or joint pain Back Pain Swelling of joints
  Stiffness

Neurologic:
- Dizziness Fainting Seizures

Hematologic:
- Ease of bruisingEase of bleeding

Endocrine:
- Head or cold intolerance Frequent urination Change in appetite
  Sweating

Psychiatric:
- Nervousness Memory Loss Stress Depression
  Weakness Tremor Numbness Tingling

________________________________ ____________________
Patient Signature Date

HIPAA 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 CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health Information” is information about you, including demographic information that may identify you and that relates to you past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities or your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may

also call you by named in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will be made only with your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes: information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your unprotected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:______________________________ Signature______________________ Date: __________

Acknowledgment Form

I acknowledge receipt of this Notice of Privacy Rights, which I have reviewed, and give my permission to **Scott D. Lauer D.O.** to use and disclose my health information in accordance with it.

______________________________ ______________________________
Name of Patient Signature of Patient

______________________________ ______________________________
Date Signature of Parent or Guardian

I give permission to **Scott D. Lauer D.O.** to release medical information to the following person(s):
(Please print names and relationship below).

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

This Authorization will expire in two (2) years from the above date unless written revocation is received.

Assignment of Benefits Form

Patient Insurance Coverage Responsibility Disclaimer and Authorization

I understand that it is my responsibility to know if Dr. Scott D. Lauer DO is an authorized provider according to my insurance contract. I also understand that Dr. Lauer is required by law and contracted to collect from me, on the date of service, any present co-payment amount required by my insurance contract.

I understand that I am responsible to know which lab and outside facilities my insurance company utilizes for all lab work, diagnostic testing, and specialist appointments If prior authorization is required by my insurance contract for diagnostic testing and specialists' appointments I realize that it is my responsibility to request a referral authorization from my primary care provider. Failure to do so may result in my insurance company denying payment for services and I will be responsible for the services performed. I authorize my insurance company to pay all benefits directly to Dr. Scott D. Lauer and thereby agree to the release of relevant medical information to insurance carriers.

Acknowledgement of Notice of Privacy Practices

I acknowledge that I have read the Notice of Privacy Practices. I understand that Dr. Scott D. Lauer may at its in discretion, change the terms and conditions of this notice. I understand the content of the Notice of Privacy Practices will be provided, upon my request.

☐ I give / ☐ I do not give (Please Check one) Dr. Scott D. Lauer's office permission to leave a message on my answering machine or with family members regarding reports, or blood work if I am not home.

Authorization to Release Information

I hereby authorize Dr. Scott D. Lauer, DO PA to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

Office Charges

I hope you will understand our office staff's time is extremely valuable having to jump through continuous hoops to collect insurance and patient payments. The following services are not reimbursable by insurance and provided at the following upfront cost: Completion of Disability/ FMLA forms ($25) and Missed Appointment fee ($50), defined as failure to notify the office greater than 24 hours prior to your scheduled visit of your inability to keep your office

appointment ($50) or scheduled surgery ($200), no exceptions. If for any reason you need copies of your medical records, there is a charge of $25 for the first 20 pages and the $.50 per page thereafter, in accordance with the Texas Medical Board. If your account is placed with our outside collections agency, a fee equal to 50% of what is owed will be applied to the balance due. Unpaid collection accounts will be terminated from the practice and records will only be released on an emergency basis until account is paid in full.

____ __________________
Patient/Responsible Party Signature Date

____ __________________
Witness Date