



Welcome letter

Dear New Patient of Optimal Health Primary Care,

This letter is to welcome you to **OPTIMAL HEALTH PRIMARY CARE**. We are located at 10120 S Eastern Ave Suite 100. Henderson NV 89052. The cross streets are *ST. ROSE and EASTERN*, directly across the street from the St. Rose Sienna hospital. You may want to plan on arriving 30 minutes early to account for difficulty finding the office, traffic, parking, and filling out any additional registration forms, allowing you full time with the doctor.

Enclosed is our new patient questionnaire packet. It can take between 45 minutes to an hour to fill this form out completely. We have found that a detailed patient history to be the most effective way for Dr. Brown to help you as best as possible. Please be sure to complete the forms before coming in at the time of your appointment.

Please understand that every patient is expected to pay their **COPAY, DEDUCTIBLE AND COINSURANCE** responsibility at the time of service for their care.

If you have an urgent need to be seen, please call as soon as possible, and we will try to accommodate you. We do our best to stay on schedule, but emergencies may sometimes cause unexpected delays. You play a major role in helping us stay on schedule. If you are running late, please phone before you come, because we may ask you to reschedule your appointment so that our other patients are not inconvenienced.

If you are unable to keep your appointment, please notify us as soon as possible. We require 24 hour notice, or you may be charged **\$50.00**. If you are assessed this fee, it is required that it be paid by the time of your next visit.

Again, Welcome to Optimal Health Primary Care. We look forward to seeing you soon and helping you achieve optimal health.

Sincerely,

Jeffrey L. Brown, DO
OPTIMAL HEALTH PRIMARY CARE



New Patient Checklist

The following is a checklist that you must have completed and returned before your initial visit with the physician. We request that you either send the signed and completed paperwork to Optimal Health Primary Care at 10120 S Eastern Ave. Suite 100 Henderson NV, 89052 or fax the signed and completed paperwork to Optimal Health Primary Care at (702) 871-7005. You may also email the signed and completed paperwork in a *PDF. attachment only* to info@optimalhealthpc.com

It is extremely **IMPORTANT** that we receive this paperwork as early as possible prior to your appointment. Your visit may be delayed if these forms are not completed and received prior to your arrival. Thank you for your cooperation.

- Confirm your appointment (date and time) with us a few days before the visit.
- Completed registration forms with NAME, DOB, SIGNATURE and DATE on each page and is sent to Optimal Health Primary Care at least 2 days before your appointment. This will save time during your initial registration.**
- Check and clarify directions to our office via maps, our web site (www.Optimalhealthpc.com), or a phone call to our office (702) 871-7004. Please allow for extra travel time during peak traffic hours. Also please remember that the physician's schedules are generally full. Therefore, if you are late for your appointment with the physician and nurse practitioner, we may have to reschedule your visit.
- We recommend that you bring your medical records related to any prior health concern tests (labs, diagnostic test(s), etc) to your visit. Please remember to copy them before your appointment.
- Remember to bring both your original insurance ID card and a photo ID issued by a local, state, or federal government agency (e.g. a driver's license; passport; military ID, etc.). We will photocopy them during your initial registration. This is a federal law passed to prevent identity theft and it applies every new patient.
- We recommend that you bring in your medication and supplements to your initial visit.

We ask that cell phones be shut off during your consultation with the doctor as well as checking in and out with the front desk to provide better communication.

Signature _____

Date _____



Biophotonic Scan	Questionnaire
Patient Name: _____	DATE: _____
Email Address: _____	

Please read before filling out the form

Dr. Brown **highly recommends the Biophotonic Scan test for ALL patients whether** new or an established patient that hasn't had this test. The basic procedure is to scan the bottom left part of your right palm through a low-energy blue light laser which is non-invasive. This measures your skin's carotenoid levels and will give you an antioxidant score. Antioxidants fight free radicals which cause disease, cancer and accelerate aging. This will tell us:

- € If you are eating the right amount of fruits and vegetables per day
- € If your vitamins and supplements are being absorbed well by your body
- € If your body has the antioxidant levels to fight disease

This Biophotonic Scan Test fee of **\$20.00** is in addition to your office visit copay, coinsurance and/or deductible(s). It is due at the time of service.

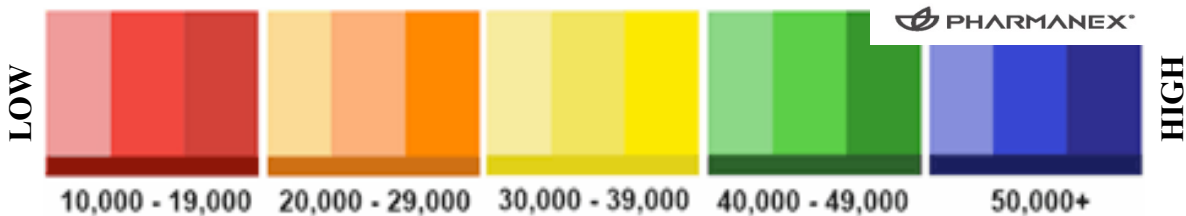
Consent to Use Scanner Data- I understand that Pharmanex® will make available to me the results of my carotenoid scan on the Pharmanex® website. I also understand that only I will be able to access my information that identifies me. I consent to allow Pharmanex® to use my information in an aggregate database for research that will not identify me to other viewers.

Signature _____ Date _____

Note: The Pharmanex® Biophotonic Scanner is not intended to be used for medical purposes. It is not a medical device or diagnostic tool of any kind and cannot diagnose, treat, mitigate, cure or prevent any disease, or affect the structure or any function of the body.

Demographic Information: Your answers will strictly be confidential									
Mark an x in the appropriate box									
Age Category	Under 18	18-24	25-34	35-44	45-54	55-64	65+		
Sex	Male	Female							
Height	Feet	Inches							
Weight	Lbs								
Do you smoke	Yes	No							
Fruits & Vegetables consumed per day on average									
	Less than 2 servings	2-3 servings	4-5 servings	6 or more servings					

FOR MEDICAL ASSISTANT OR STAFF REPRESENTATIVE TO FILL OUT:



SCAN CARD ID: _____ SKIN CAROTENOID SCORE: _____



10120 S EASTERN AVE SUITE 100 HENDERSON NV 89052

(702) 871-7004 | F (702) 871-7005 | WWW.OPTIMALHEALTHPC.COM

PATIENT INFORMATION

DATE: _____

First Name: _____ Last Name: _____

DOB: _____ SSN: _____ Gender: M F

Address: _____ City: _____ ST: _____ Zip: _____

Home Phone #: _____ Cell #: _____ Other #: _____

Marital Status: Single Married Widowed Divorced

Race: _____ Ethnicity: _____ Language: _____

Occupation: _____ Work Phone #: _____ Ext: _____

Emergency Contact: _____ Relation: _____ Telephone #: _____

INSURANCE INFORMATION

(PLEASE GIVE YOUR PICTURE ID AND INSURANCE CARD TO THE FRONT OFFICE.)

If you have a TERTIARY insurance please have the same information needed below written at the back of this form.

Primary Insurance: _____ Telephone #: _____

Address: _____ City: _____ ST: _____ Zip: _____

Primary holder of Insurance: _____ Relationship to insured: _____

DOB: _____ SSN: _____ Effective Date: _____

Policy Number: _____ Group Number: _____

Secondary Insurance: _____ Telephone #: _____

Address: _____ City: _____ ST: _____ Zip: _____

Primary holder of Insurance: _____ Relationship to insured: _____

DOB: _____ SSN: _____ Effective Date: _____

Policy Number: _____ Group Number: _____

Referred By/How did you hear about us:

SIGNATURE: _____

DATE: _____

Health History

Patient Name: _____

DATE: _____

Check any you may have, have had, or leave blank if **NONE**:

- | | | |
|---|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypertension | <input type="checkbox"/> HIV/ AIDS |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Skin Disease | <input type="checkbox"/> Bleeding Tendency |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Stroke | <input type="checkbox"/> Blood Transfusions |
| <input type="checkbox"/> Drug & Alcohol | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Miscarriages |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Cararact | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Hepatitis (B, C) | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Other(s): _____ | | |

Surgical/Injury History

Surgery: _____	Year: _____
Surgery: _____	Year: _____
Surgery: _____	Year: _____
Surgery: _____	Year: _____

Family History

Disease/Illness:	Family Member:	Paternal/Maternal side:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication List

if you have any further medication please list them at the back of this form

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you ALLERGIC to any medication? Yes No If YES, please list medication:

Medication	Reaction
_____	_____
_____	_____

Supplement List

Supplement	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

SIGNATURE: _____

DATE: _____

Social History and Health Habits

Patient Name: _____

DATE: _____

- Are you sexually active? Yes No
- Are you in an abusive relationship? Yes No
- Tobacco use: Cigarettes or Cigars? Qty/Day: _____ Yes No
- Alcohol use: Wine, Liquor or Beer? Approx. Amt/Week: _____ Yes No
- Illegal Drug (s) use: Type(s): _____ Yes No
- Caffeine use: Coffee, Tea or Soda? Cups/Day: _____ Yes No
- How many glasses/d of water do you drink a day: _____
- Do you consider yourself: Underweight Overweight Just right
- Exercise Habits: 5-7 days/week 3-4 days/week 1-2 days/week
- Have you had an unintentional weight loss of 10 pounds or more in the last three months?

- Is your Job associated with potentially harmful chemicals (e.g. pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g. firearm, etc)? _____
- Major cause(s) of stress (e.g. changes in work, residence, finances, legal problems):

- Rate the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest):

	1	2	3	4	5	6	7	8	9	10
--	---	---	---	---	---	---	---	---	---	----
- Rate the following on a scale of 1 to 10 (10 being the highest):

Energy:	1	2	3	4	5	6	7	8	9	10
Mood:	1	2	3	4	5	6	7	8	9	10
Sleep:	1	2	3	4	5	6	7	8	9	10

Health Issues your most concerned with:

Primary Problem: _____ Duration: _____

Secondary Problem: _____ Duration: _____

Minor Problem(s): _____ Duration: _____

Health Goals:

Primary Goal: _____

Secondary Goal: _____

Tertiary Goal: _____

Would you like more information about:

- Anti-Aging Skin Care Weight Loss Vitamin Supplementation Pain Management

SIGNATURE: _____

DATE: _____

Symptom Questionnaire: Rate your symptoms on how you have been feeling in the past 30-days. Include symptoms you have learned to live with and/or associated with getting older.

Patient Name:

DATE:

Nausea & Vomiting

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Diarrhea

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Constipation

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Bloated Feeling

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Belching or Passing Gas

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Stomach Pains or Cramps

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Heartburn

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Blood & Mucous in Stools

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Pains or Aches in Joints

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Arthritis

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Stiffness, Limited Movement

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Pains or Aches in Muscles

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Feeling Weak & Tired

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Swollen, Tender Joints

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Growing Pains in Legs

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Binge Eating / Drinking

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Craving Certain Foods

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Excessive Weight

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Compulsive Eating

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Water Retention

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Apathy, Lethargy

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Attention Deficit

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Fatigue

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Hyperactivity

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Symptom Questionnaire (continued)

Patient Name:

DATE:

Restlessness

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Poor Physical Coordination

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Stuttering or Stammering

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Slurred Speech

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Frequent Illness

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Frequent or Urgent Urination

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Genital Itch or Discharge

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Anal Itching

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Mood Swings

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Anxiety, Fear, Nervousness

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Angry, Irritable, Aggressive

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Argumentative

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Frustrated, Often Cry

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Depression

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Irritable, Jittery, Moody

- Never
- Sometimes, *not* severe
- Sometimes, *severe*
- Often, *not* severe
- Often, *severe*

Poor Memory

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Difficulty Completing Projects

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Difficulty with Mathematics

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Underachiever in School

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Poor / Short Attention Span

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Confusion

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Easily Distracted

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Difficulty Making Decisions

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Chronically Tired

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Symptom Questionnaire (continued)

Patient Name:

DATE:

Headaches

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Dizziness

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Rashes

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Indigestion

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Mucous in Stool

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Foul Smelling Gas

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Cold Sores

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Bad Breath

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Burning of Eyes

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Post-Nasal Drip

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Cough

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Nasal Itching

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Ear Pain / Hearing Loss

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Pressure in Ears

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Cravings for Candy, Sweets

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

(Women) Vaginitis, Discharge

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

(Women) Irregular Menses

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

(Women) PMS

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

Loss of Sex Drive

- Never
- Sometimes, *not* severe
- Sometimes, severe
- Often, *not* severe
- Often, severe

SIGNATURE:

DATE:

FINANCIAL POLICY

Patient Name: _____

DOB: _____

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please Understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy.

Please read, initial, and sign before treatment.

_____ PAYMENT IS DUE IN FULL AT THE TIME OF SERVICE.

_____ There is a **\$50.00 no call/no show fee** for missed appointments.

_____ We accept **cash, credit card and personal checks only after the initial visit.**

_____ ALL PATIENTS MUST COMPLETE OUR INFORMATION AND INSURANCE FORM BEFORE SEEING THE DOCTOR.

_____ Medical records supplied to the patient or other 3rd party will be charged **\$0.60 per page** for anything greater than 10 pages.

_____ Please be advised, you will receive a separate bill from the laboratory, for any specimen(s) collected and sent out of the office.

_____ All accounts, ninety (90) days past due will automatically be assigned to a collection agency unless prior arrangements have been made.

_____ Optimal Health Primary Care will complete forms needed to file a claim for benefits from my insurance carrier, but it remains my financial responsibility to pay for services rendered.

_____ WE RESERVE THE RIGHT TO CHARGE a \$60.00 FEE FOR ANY PHYSICIAN LETTER, SHORT TERM DISABILITY FORMS, FMLA FORMS, and OR ANY OTHER LETTERS/FORMS CONSTRUCTED OR FILLED OUT BY THE PHYSICIAN.

_____ It is a courtesy to me, the patient, that Optimal Health Primary Care verifies insurance benefits, but ultimately it is my responsibility to know what my benefits are, including where to go for my diagnostic testing, laboratory testing and prescription medications.

_____ I authorize Optimal Health Primary Care to release any information necessary to a requesting physician, hospital, or any other medical health facility.

_____ I understand that I must provide Optimal Health Primary Care with a valid copy of a current ID. If I fail to do so, I understand that I must make a prepayment of \$100.00 prior to seeing the physician. This will be applied to the total charges for services rendered, if I do not have current health insurance. (NRS 453.431.2)

_____ If for any reason, I give fraudulent insurance or personal information to Optimal Health Primary Care or their staff that prevents a claim from being paid, I will be assessed a \$100.00 fee and billed directly for any/all services provided.

SIGNATURE: _____

DATE: _____

CONTRACT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Patient Name: _____

DOB: _____

We reserve the right not to prescribe narcotic medications. If you take narcotic medication for pain control on a regular basis you must see a pain management physician. **No** narcotic prescriptions will be given for **new patients** on the **initial visit** until a complete work up has been performed and old records have been received.

Controlled substance medications (narcotics, anti anxiety, sleeping medications etc.) are very useful, but have high potential for misuse and abuse. These drugs are closely controlled by local state, and federal government. They are intended to relieve pain, to improve function and/or ability to work, not simply to feel good. If my doctor prescribes such medications for me to help manage my pain, I agree to the following conditions:

1. I am responsible for my controlled substance medication. If the prescription or medication is lost misplaced, or stolen, or if I use it up sooner than prescribed, I understand that it will not be replaced.

2. I will not request nor accept controlled substance medication from any other physician or individual while I am receiving such medication from my doctor.

3. Refills of controlled substance medication:

a. Will be made only during regular appointments, Monday thru Friday.

b. Will not be made if I **"RUN OUT EARLY"**. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount left.

c. Will not be made as an "EMERGENCY". Such as on Friday afternoon because suddenly realized I will "RUN OUT TOMORROW". I will keep track of my medication and plan ahead.

4. I understand that if I violate any of the above conditions, my controlled substance prescriptions and / or treatment with Optimal Health Primary Care provider will be ended immediately. If the violation involves obtaining controlled substance from another individual, as described above, I may also be reported to local medical facilities and other authorities.

I have been informed about side effects, including normal psychological effects of tolerance (need for more medication to achieve the same pain relief) and dependence (withdrawal will occur if I stop abruptly.)

SIGNATURE: _____

DATE: _____



Check **ABSENT, MILD, MODERATE OR SEVERE** on any that you currently have or have had experienced in the past 3 months. Check **ABSENT** if you have not experienced any of the symptoms.

FEMALE

PATIENT NAME:					DATE:				
	ABSENT	MILD	MODERATE	SEVERE		ABSENT	MILD	MODERATE	SEVERE
Anxiety					Bladder symptoms				
Breast tenderness					PMS symptoms				
Depression					Joint pain				
Dry skin/hair					Memory loss				
Fibrocystic breast (Breast Lumps)					Headaches				
Heavy menses					Fatigue				
Irregular menses					Fluid retention				
Irritability					Hot flashes				
Cold body temperature					Mood Swings				
Harder to reach climax					Night sweats				
Difficulty falling asleep					Hair Loss				
Vaginal dryness					Decreased sex drive				
Weight gain					Interrupted sleep				

SIGNATURE: _____

MALE

PATIENT NAME:					DATE:				
	ABSENT	MILD	MODERATE	SEVERE		ABSENT	MILD	MODERATE	SEVERE
Aches & Pain					Anxiety				
Loss of initiative/drive					Hair Loss				
Difficulty falling asleep					Frequent Urination				
Carb. Cravings					Mood Swings				
Decreased Muscle Mass					Weak urine stream				
Fatigue					Headaches				
Foggy Mind					Weight Gain				
Interrupted Sleep					Irritability				
Cold Body Temperature					Night Sweats				
Difficulty obtaining erection					Decreased Sex drive				
Difficulty maintaining erection					Depression				
Waking up un-refreshed					Poor Stamina				

SIGNATURE: _____

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFITS

Patient Name: _____

DOB: _____

PLEASE READ, INITIAL AND SIGN.

_____ The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize OPTIMAL HEALTH PRIMARY CARE to release any information required to process my claims.

_____ I understand that all **co-payments, co-insurance**, and/or **deductibles** are due at the time of service – **NO EXCEPTIONS**. It is my responsibility to inform this office of any charges in my insurance coverage. I am responsible for knowing my benefits and will be responsible for contacting my insurance carrier for details. I will be financially responsible for all services rendered that are **NOT** covered or paid by my insurance plan and if my account is turned over for outside collections.

_____ I understand that the Notice of Privacy Practices of OPTIMAL HEALTH PRIMARY CARE is available at the front desk upon request.

▪ In addition, I also give consent to Optimal Health Primary Care to disclose my protected healthcare information to the following persons and/or people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Credit Card on File Authorization

In accordance with our **Office Financial Policy** and **Office Policy on Insurance Coverage**, a credit card authorization form is required to be on file to settle patient balances on the day they occur. Therefore, please complete the information below.

Patient Name: _____

Cardholder Name: _____

Credit Card #: _____

Expiration date: _____ / _____ Any single charge will not exceed: \$100.00

Billing Address of Credit Card: _____

City: _____ State: _____ Zip Code: _____

I hereby authorize **Optimal Health Primary Care** to charge the above credit card for any patient balance due only, unless otherwise specified by the cardholder. I understand that I will be telephoned prior to any charges run on the credit card. This authorization will remain valid for 1 year from the date of the signature.

SIGNATURE: _____

DATE: _____