Nuwave Medical, PLLC
PATIENT REGISTRATION FORM

Date:____________

PATIENT INFORMATION

Last Name:____________________ First Name:______________________ M Initial:_______

SS# ___________________________ Date of Birth: _______/__________/___________

Address ____

City/St/ Zip____

Home Phone #_______________________ Cell Phone # ____________________________

Employer:____________________________ Work Phone #__________________________

Work Address ____________________________ City/State/ Zip__________________________

How did you hear about our clinic?____

Email:____

EMERGENCY CONTACT

Name:__________________________ Relationship to Patient ______________________

Home Phone #____________________ Cell Phone #_____________________________

INSURANCE INFORMATION

Primary Insurance:____________________ Member ID# ____________________________

Address___________________________ Group# ____________________________________

City/St/Zip_________________________ Phone #_____________________________________

Policy Owner ____________________________**Insured D.O.B** ______/__________/______

Patient Relationship to Policy Owner: ____________________________________

POLICY HOLDER INFORMATION (if different then yourself)

Last Name:___________________________ First Name:___________________________

Address: ____

City/St/Zip_____________________________ Date of Birth _________/_________/__________

SS#___________________________________

Employer ______________________________ Work Phone ___________________________

HEALTH HISTORY QUESTIONNAIRE

Primary Care Doctor (PCP) : ____________________Date of Last Physical Exam: ________

PERSONAL HEALTH HISTORY

PAST MEDICAL HISTORY: CIRCLE ALL THAT APPLY
Cardiovascular Disease: Chest Pain - Heart Failure - Murmur - Vascular Disease - Blood Clots Fainting - Lower Extremity Edema
Respiratory: Shortness of Breath – Asthma – Bronchitis- Pneumonia – Allergies – Hay Fever
Gastrointestinal: Lactose Intolerance – Gallbladder – Gall Stones – Diarrhea – Constipation
Genitourinary: – Overactive Bladder – Frequent Urination – Painful Urination- Difficult Urination – Prostate Enlargement- BPH.
Diabetes - High Blood Pressure - Cancer – Depression – High Cholesterol – Sleep Apnea

Surgeries:

Year	Reason	Hospital

List your prescribed drugs and over-the-counter, such as vitamins and inhalers.

Name the Drug	Strength	Frequency Taken

Preferred Pharmacy: ______________________________**Phone Number:**________________

Allergies to Medications

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

Exercise	☐ Sedentary (No exercise) ☐ Mild exercise ☐ Occasional vigorous exercise ☐ Regular vigorous exercise

Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?		

SYMPTOMS OF LOW TESTOSTERONE LEVELS						
Alcohol	☐ Yes ☐ No	Tobacco	☐ Yes ☐ No			

Difficulty concentrating	☐ Yes	☐ No
Moodiness	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Weight Gain	☐ Yes	☐ No
Decreasing sex drive	☐ Yes	☐ No
Increasing Fatigue	☐ Yes	☐ No
Decreasing energy	☐ Yes	☐ No
Daytime Sleepiness	☐ Yes	☐ No
Poor Sleep Habits	☐ Yes	☐ No
Erectile Dysfunction	☐ Yes	☐ No

I understand periodic blood tests are necessary when receiving testosterone replacement therapy. Several insurance policies have strict requirements for blood testing. If your lab work needs to go to a specific outside location please let us know.

Each patient is expected to have a full yearly physical. If you do not have a primary care physician NuWave Medical, PLLC. will assist in locating one for you.

Your signature constitutes your understanding of the above information.

Signature:______________________________ Date:____________________

NOTICE OF OUR PRIVACY PRACTICES

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information.

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and your treatment and the services we provide for you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at this time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may us and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

NuWave Medical, PLLC.
283 Commack RD
Commack, NY, 11725
Nuwavemedicalny.com
631-343-7144 Fax 631-670-7035

C. WE MAY USE AND DISCLOSURE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. Any of the people who work for our practice – including, but not limited to, our doctors and nurses, or indirectly with any provider we refer you to – may use or disclose your IIHI in order to treat you, or to assist others in your treatment. Additionally, we may need to disclose your IIHI to others who may assist in your care, such as your spouse, children, or parents.
2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment and health status to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members or insurance companies. Also, we may use your IIHI to bill you directly for services and items.
3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our practice.
4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you or a family member who answers the phone (or to leave a recorded message) to remind you of an upcoming appointment.
5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.
7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to our office for care. In this example, the babysitter may have access to this child's medical information.
8. **Disclosures Required by Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. In general, we will require that the party that requests your records provide a records-release form, signed by you within the last 3 months.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organs and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation in you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes <u>except when</u>: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a research that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the research only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research, and if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for worker's compensation and similar programs.

Patient Signature: ______________________________ Date: ______________

Witness Signature: ______________________________ Date: ______________

FINANCIAL AGREEMENT

NuWave Medical, PLLC. relies on open communication with our patients regarding our financial policy and will assist in providing the best service to you.

Please select from the following payment choices:

_____ Self-Pay – I agree to pay my balance in full at the time of service.

_____ Private Insurance – NuWave Medical, PLLC. will bill your primary insurance.

INSURANCE BILLING

As an extended service to you, a claim will be filed with your primary insurance carrier for every service you receive at NuWave Medical, PLLC.

Although we are happy to assist you in filing a claim with your insurance carrier, it is important for you to remember that you are the insured. You, or your employer, have selected the carrier and your coverage. NuWave Medical, PLLC. strongly encourages you to question your insurance carrier regarding delays in payment and/or the amounts paid. We will make every effort to follow up on the claims we have filed on your behalf, but we cannot accept the responsibility for misquoted benefits, insufficient coverage or slow payment.

In assisting you to file your insurance claims, we will need complete and accurate information. If for any reason, your insurance coverage should change, please inform us immediately so that NuWave Medical, PLLC.may make the appropriate changes to your account.

PAYMENTS

Please be aware that NuWave Medical PLLC. requires payment for all co-pays, deductibles, coinsurances, and supplies that your insurance will not cover at the time of service, unless other arrangements have been made with our facility.

As we receive payments or notifications from your insurance company, we will present you with a statement. Payment of this/any outstanding balance will be due no later than 30 days from the date of statement.

In the event that your account becomes delinquent and is therefore in default of payment, you will be responsible for the principal amount owed and all reasonable costs associated with the collection of this debt, including: collection service fees, attorney's fees, court costs, and additional legal expenses associated with the recovery of the debt.

Please contact us at any time with any questions regarding your account and/or balance.

_______________________________________ _____________________

Patient Signature Date

Nuwave Medical, PLLC

Patient Name: ______________________ Chart #: ______________ Date: ______________

Informed Consent
For Testosterone Replacement Therapy (TRT)

It is important for you to be aware of the potential risks, as well as the benefits, before deciding on whether to begin Testosterone Replacement Therapy. You should also be aware of alternatives to TRT, including not receiving the treatment. Any questions that you may have should be brought to our attention. Your provider will answer all of your questions to your satisfaction prior to starting treatment.

Directions: Initial beside each statement that you have read, understand, and agree with.

___ 1. This is my consent for Nuwave Medical, PLLC, including any physician, PA or NP who works with the practice, to begin my treatment of Testosterone Replacement Therapy.
___ 2. It has been explained to me, and I fully understand, that occasionally, as with any medical treatment, there can be side effects or complications: With TRT, known possible complications include Acne, Breast Enlargement, Mood Swings, or the following:
___ 3. Fluid retention – This can cause problems for patients with heart, kidney, or liver disease.
___ 4. Sleep disturbance – This is called sleep apnea and is more likely to occur with patients who have lung disease or who are obese.
___ 5. Prostate enlargement - This may cause problems with urination.
___ 6. Changes in cholesterol levels, red blood cell levels, liver function or other hormone levels.
___ 7. I understand that Nuwave Medical, PLLC will therefore perform periodic blood tests to monitor my blood levels.
___ 8. I understand that the results of this treatment are not guaranteed and that if I stop treatment, my condition may return or worsen.
___ 9. I have had an opportunity to discuss my complete past medical history with Nuwave Medical, PLLC. All of my questions concerning the risks, benefits, and alternatives have been answered. I am satisfied with the answers.
___10. I understand that the initial and periodic physical exams performed by Nuwave Medical, PLLC do NOT replace a full physical exam performed by my personal health care provider.
___11. I therefore agree to have my personal health care provider perform a yearly full physical exam including a **digital rectal exam.** If I do not have a personal health care provider, Nuwave Medical, PLLC will assist in locating one for me.
___12. I agree that while a patient of Nuwave Medical, PLLC, I will take no anabolic steroids, testosterone precursor supplements or any other form of testosterone unless prescribed by Nuwave Medical, PLLC. I understand that doing so can endanger my health and may lead to my being discharged as a patient of Nuwave Medical, PLLC.

____

Patient Date

____

Witness Date