Onyx Medical Practitioner PC
NuWave Medical PLLC
283 Commack Rd. #115 Commack, NY. 11725
P (631)343-7144 F (631)670-7035

NEW PATIENT INTAKE FORM

MH

PLEASE PRINT AND COMPLETE ALL ENTRIES

FIRST NAME	LAST NAME	DATE OF BIRTH
		_____/_____/_____

SEX	SOCIAL SECURITY	PHONE NUMBER	EMAIL ADDRESS
❑ Male ❑ Female			

ADDRESS		
CITY	STATE	ZIP CODE

MARITAL STATUS	SPOUSES NAME	SPOUSE PHONE NUMBER
❑SINGLE ❑MARRIED		
EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER

INSURANCE INFORMATION

DO YOU HAVE INSURANCE?	PRIMARY CARD HOLDER	PRIMARY POLICY HOLDER NAME
❑YES ❑NO	❑SELF ❑SPOUSE. ❑PARENT. ❑OTHER_____	
PRIMARY INSURANCE COMPANY	PRIMARY ID NUMBER	PRIMARY GROUP NUMBER
DO YOU HAVE SECONDARY INSURANCE?	SECONDARY CARD HOLDER	SECONDARY POLICY HOLDER NAME
❑YES ❑NO	❑SELF ❑SPOUSE. ❑PARENT. ❑OTHER_____	
SECONDARY INSURANCE COMPANY	SECONDARY ID NUMBER	SECONDARY GROUP NUMBER

PAYMENT POLICIES

- You are financially responsible for anything insurance does not cover. All copays are due and payable at each visit. The amount your insurance will allow and pay for and your financial responsibility is determined by your insurance company and the policy you have chosen. Your claim will be processed according to the benefits of your insurance plan. The deductible, co-insurance and co-pay are your financial responsibility. It is your responsibility to understand your insurance plan.
- $50 No Show Fee for any Missed Appointment that was not cancelled or rescheduled 24 hours prior to the appointment. Please be considerate and call at least 24 hours before your appointment if you cannot come in.
- $35 NSF charge for any returned check from the bank.
- If you are a private patient without insurance, all charges are due at the time of the visit.

PRESCRIPTION POLICY

PHARMACY NAME	PHARMACY PHONE NUMBER

- Please do not wait until your last pill to call for a refill. There is a 72 hour turn around for prescription refills. If you have not seen the Physician in six months, the prescription will be Denied.

PATIENT SIGNATURE	**DATE**

PATIENT NAME: _____ DOB: _____

PATIENT MEDICAL HISTORY

Allergies

❑ NONE/Known Allergies ❑ Adhesive Tape ❑ Anesthesia ❑ Aspirin ❑ Codeine
❑ Dairy Products ❑ Iodine/Shellfish/Contrast ❑ Latex ❑ Morphine ❑ Penicillin

OTHER:

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	FATHER
Anesthesia Problems		
Arthritis		
Cancer		
Diabetes		
Heart Problems		
Hypertension		
Stroke		
Thyroid Disorder		

SOCIAL HISTORY

☐**Yes** ☐**No -** Do you drink alcohol? ☐ Daily ☐Weekly ☐Infrequently ☐ Recovering Alcoholic
☐**Yes** ☐**No -** Do you smoke? ☐ Smoke (___packs per day) ☐ Chew
☐**Yes** ☐**No -** Do you drink caffeine? ☐ Daily ☐Weekly ☐Infrequently
☐**Yes** ☐**No –** Are you sexually active?
☐**Yes** ☐**No –** Do you wish to be checked for STDs?

Surgical History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	LOCATION

Medical History: Have you ever had any of the following?

❑ NONE of the problems listed
❑ Allergies
❑ Anemia
❑ Arthritis conditions
❑ Asthma
❑ Arterial fibrillation
❑ Bleeding problems
❑ BPH
❑ CAD coronary artery disease
❑ Cancer
❑ Cardiac arrest
❑ Celiac disease
❑ Chest pain
❑ Congestive heart failure
❑ Chronic fatigue syndrome
❑ Depression
❑ Diabetes
❑ Drug/alcohol abuse
❑ Erectile dysfunction
❑ Fibromyalgia
❑ Gerd
❑ Heart disease
❑ Hyperinsulinemia
❑ Hyperlipidemia
❑ Hypertension
❑ Hypogonadism male
❑ Hypothyroidism
❑ Infection problems
❑ Insomnia
❑ Irritable bowel syndrome
❑ Kidney problems
❑ Menopause
❑ Migraines/headaches
❑ Neuropathy
❑ Onychomycosis
❑ Organ injury
❑ Osteoporosis
❑ Pulmonary embolism
❑ Seizure disorders
❑ Shortness of breath
❑ Sinus conditions
❑ Stroke
❑ Syndrome X
❑ Tremors
❑ Wheat allergy

Medications: List any medications you are currently taking (please include over the counter medications):

PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE

MEDICATION	DOSAGE	PRESCRIBING DOCTOR

PATIENT NAME: _____ DOB: _____

MALE: HEALTHY HABITS AND PERSONAL SAFETY:

Exercise: Sedentary (No Exercise) [ ] Mild Exercise [ ] Occasional Vigorous Exercise [ ] Regular Vigorous Exercise [ ]

PLEASE ANSWER TO THE BEST OF YOUR ABILITY	YES	NO
Do you have any children?		
Do you plan on having any children?		
Do you feel pain or burning with urination?		
Any blood in your urine?		
Do you feel burning discharge from your penis?		
Has the force of your urination decreased?		
Have you had any kidney, bladder, or prostate infections within the last 12 months?		
Do you have any problems with emptying your bladder completely?		
Any difficulty with erection or ejaculations?		
Any testicle pain or swelling?		
Date of last prostate and rectal exam: _____/_____/		

SYMPTOMS OF LOW TESTOSTERONE LEVELS

PLEASE ANSWER TO THE BEST OF YOUR ABILITY	YES	NO
Difficulty concentrating?		
Moodiness?		
Depression?		
Weight Gain?		
Decreased Sex Drive?		
Increasing Fatigue?		
Decreasing Energy?		
Daytime Sleepiness?		
Poor Sleeping Habits?		
Erectile Dysfunction?		

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.

Signature:_____ **Date:**_____

Informed Consent: Testosterone Replacement Therapy (TRT)

It is important for you to be aware of potential risks, as well as benefits, before deciding on whether to begin Testosterone Replacement Therapy. You should also beware of alternatives for TRT, including not receiving the treatment.

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

_____1. This is my consent for Nuwave Medical, PPLC 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: 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 cells levels, liver function or other hormone levels.

____7. I understand that Nuwave Medical, PLLC will therefore perform periodic blood test 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 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 location one for you.

___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 being discharged as a patient of NuWave Medical, PLLC.

_____

Patient Written Name Patient Signature Date

_____

Witness Date

Financial Policy:
Updated Effective August 1, 2024

In Network: (BCBS, GHI & Medicare)

Copayments: We will be collecting all copayments as established by your insurance carrier prior to treatments. As policies and procedures have changed, we regret that we can no longer discount or waive any copayments for any reason.
Co-Insurance will be billed to you after we receive payments from your insurance carrier. The amount they apply to your coinsurance will be your responsibility and billed to you.
Deductibles: All services where payments are applied to your deductible will be billed to you as it is your responsibility according to the agreement you have with your insurance carrier.

Out of Network: (GHI, Multiplan, 1199, MagnaCare & Aetna)

Deductibles: We ask that all patients contribute towards deductibles on all dates of services until your deductible is satisfied. You will be responsible for prepayment prior to treatment. (Excludes GHI)

Co-Insurance will be billed to you after we receive payments from your insurance carrier. The amount they apply to your coinsurance will be your responsibility.
If we accept your insurance, and we are out of network, any services not covered by your insurance company will be your responsibility. We will not bill you more than our self-pay rates for the dates of service not covered.
*Some policies have an out of network copayment which will be collected prior to treatment in addition to any payments towards deductibles.

Out of Network payments are often mailed to you as the member. You will be responsible for bringing in that payment along with all supporting documents so we can apply any monies accordingly.
**There are times that your insurance company may decide that services rendered to you are not covered for various reasons. They may consider some therapies experimental or not medically necessary despite a physician's findings and established treatment plans. If your insurance company retracts payments made to us for your services, you will be billed for all dates of services accordingly. **

Self-Pay:

CIGNA, UHC/Oxford/The Empire Plan (NYSHIP)
We will no longer be accepting your insurance for services rendered. We will offer weekly, bi-weekly, and monthly self-pay plans. We will provide you, if requested, with claim forms for you to submit your claims to your insurance company for reimbursement.

I have read and agree with this financial policy and understand my financial responsibilities for services rendered by Nuwave Medical PLLC.

Patient Name: _____

Patient Signature: _____ Date: _____

Notice of Privacy Practices
Onyx Medical Practionier PC
Officer: Sekuleo Gathers, MD

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. It also discusses the uses and disclosure we will make of your protected health information. We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of the notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a written copy of our most current privacy policy notice from the Practice's Privacy Officer.

This office has always recognized the importance of privacy; this new federal law formalizes practices that have been followed routinely.

By the law, consent is not required to discuss your medical treatment with your other doctors or healthcare providers. This also allows for a prescription to be called into your pharmacy. Additionally, none is needed in the course of carrying out healthcare operations, such as quality assessment, or in communication with your insurance carrier for payment related issues, or for incidental uses, such as announcing a name in a waiting room or the use of sign-in sheets.

However, this office has always gone one step further in protecting you and does not believe in releasing specific information about you to any business or governmental entity without your written consent. Specific authorization is required to disclose protected information in non-routine circumstances, such as your employer or for use in marketing a product to you.

Medical information about you may be released for research and public health uses, as long as you are not individually identified.

We may contact you to provide appointment reminders for treatment or medical care, and also to recommend possible treatment alternatives or other health-related benefits and services that may be if interest to you.

You have the right to review when and to whom your information was released.

You may suggest additional restrictions with regard to certain uses and disclosures, if you wish.

Should you believe that your privacy rights have been compromised, you may report the violation, without penalty to you to, this office or the Secretary of Health.

This law requires that you acknowledge receipt of this notice; this has been included on the signature release on the bottom of this form.

You have the right to inspect and copy your health information; you must submit your request in writing to the Practice's Privacy Officer. If you request a copy of your health information, we may charge you a fee for the costs of copying and mailing your records, as well as other costs associated with your request.

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I acknowledge that I have read and understand the above Notice of Privacy Practices.

Signature: _____ Date: _____

Relationship to Patient: _____