Acknowledgement of Privacy Practices

Receipt of Notice of privacy practices acknowledgement: I have received or reviewed the privacy practice notice for Low T Center and understand the situations in which this practice may need to utilize or release my medical records.

_________________________  _______________________
Patient Signature                        Date

Consent to Obtain Medication History

I authorize the Low T Center to obtain my medication history from the e-prescribing network system. This information will be used by the providers of the Low T Center for the sole purpose of keeping a current and accurate listing of medications.

_________________________  _______________________
Patient Signature                        Date

Consent to Audio or Video Recording Devices

We may use audio or video recording devices to ensure that you have a quality patient experience, or to facilitate treatment. As part of this consent, you give us permission to utilize such audio or video recordings internally for purposes of quality assurance, training and/or safety compliance.

_________________________  _______________________
Patient Signature                        Date

Consent to Have Blood Drawn for Treatment/Testing

I authorize the medical staff at Low T Center to obtain a blood sample for the purpose of running the panel of labs included in our Low T Comprehensive Assessment.

_________________________  _______________________
Patient Signature                        Date

Financial Consent for Comprehensive Assessment

_____ I agree to pay a self-pay rate of $99.00 to have my Low T Comprehensive assessment.

_________________________  _______________________
Patient Signature                        Date
Authorization for Release of Protected Health Information

PATIENT NAME: «PtFullName»  DOB: «PtDOB»

CHECK ONE:

_____ I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information ("PHI") described below to: Low T Center

via Fax @ ____________________________________ (45 CFR 164.530(c)) OR

_____ I hereby authorize my healthcare providers at Low T Center to release and/or disclose the protected health information ("PHI") described below to:

Name: ____________________________________ Relationship: ____________________________

Purpose of Release: ______________________ by _____ Pick-up by _________________________

Other: __________________________________  _____ Email* @___________________________

(*not recommended)

2. Authorization for release of PHI covering (check one)

_____ Last Labs Only

_____ All records from (date) _________________ - to (date)_______________________

_____ All past, present and future periods.

3. I hereby authorize the release of the above PHI as follows (check one):

a. _____ my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse); OR

b. _____ my complete health record with the exception of the following information (check appropriate):

_____ Mental health records

_____ Communicable diseases (including HIV and AIDS)

_____ Alcohol/drug abuse treatment

Other (please specify): __________________________________________________________.

This authorization is valid until revoked by me in writing.

_________________________________________ OR ________________________________

Patient Signature Authorized Patient Representative Signature Date
NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.
When it comes to your health information, our Providers take your privacy and security seriously. This policy explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record
You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information usually within 20 days of your request. We may charge a reasonable, cost-based fee for this service. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Ask us to correct your medical record
You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.

Request confidential communications
You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share
You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for services or health care not covered by your health plan or insurance, such as out-of-pocket costs, you may ask us not to share this information. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information
You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
If you have given someone medical power of attorney (not a durable power of attorney or a general power of attorney) or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint
You can file a complaint if you feel we have violated your privacy rights. If you feel your rights have been violated by contacting us as follows: Office of General Counsel, 2001 N. 1st Avenue, Seattle, WA 98109, or calling 1-877-659-7591.

Your Choices
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to: (i) Share information with your family, close friends, or others involved in your care. (ii) Share information in a disability situation. (iii) Share information through communication instructions that you provide to us (e.g., email, etc.) in your care. (iv) Share information in a medical or public health situation.

When We Need Your Permission
We will never sell your information, however when you give us written permission, we may use your information for marketing purposes.

How we typically use or share your health information?
We use and disclose your health information for treatment, payment, care coordination, and other activities.

How else we can use or share your health information?
We are allowed and required to share your health information in certain situations. Usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the laws before we can share your health information for these purposes. For more information see: www.hhs.gov/orhp/privacy/hhip/understanding/consumers/index.htm.

Changes to the Terms of This Notice
We can change the terms of this notice, and the changes will apply to all health information we have about you. The new notice will be available upon request, in our office, and on our web site. This Notice of Privacy Practices applies to the following organizations: Low T Physicians Service, PLLC, its affiliated providers, and your business associates, Low T Centers, Inc. and its subsidiaries and affiliates.
PATIENT INFORMATION

How did you hear about Low T Center? ____________________________

Last Name: «PtLastName» First Name: «PtFirstName» Middle Initial: «PtMiddleName»

Preferred Name: _________________ Email: __________________________

Address: __________________________ City/St/Zip: ______________________

SSN: __________________ Date of Birth: «PtDOB» Age: «PtAgeYears»

Race & Ethnicity: □ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ White □ Other Race

Home Phone: __________________________ Cell Phone: __________________________

May we send you a text message reminder the day before your appointment? (Circle one) YES NO

Employer/Title: __________________________ Work Phone: __________________________

Work Address: __________________________ City/St/Zip: ______________________

Do you desire more children: □ Yes □ No

Primary Symptoms: Have you experienced any of the following symptoms?

□ Decreased libido □ Decreased spontaneous erection □ Hot flushes □ Unusual sweating

□ Breast discomfort □ Gynecomastia □ Noticeable decrease in testicular size

□ Testes that are less than 2.5cm in length □ Loss of axillary or pubic hair

Secondary Symptoms: Have you experienced any of the following symptoms?

□ Weight Gain □ Fatigue □ Moodiness □ Decrease mental clarity

Yes/No Questionnaire
Do you currently suffer from this condition?

□ High Cholesterol

Is this condition actively being managed by a physician? ____________

If not actively managed, are you interested in Low T managing this condition? ____________

□ High Blood Pressure

Is this condition actively being managed by a physician? ____________

If not actively managed, are you interested in Low T managing this condition? ____________

□ Diabetes

Is this condition actively being managed by a physician? ____________

If not actively managed, are you interested in Low T managing this condition? ____________

□ Weight Gain

Is this condition actively being managed by a physician? ____________

If not actively managed, are you interested in Low T managing this condition? ____________

□ Low Thyroid

Is this condition actively being managed by a physician? ____________

If not actively managed, are you interested in Low T managing this condition? ____________