DAY 1

Low T Center
Reinventing Men's Healthcare

NEW PATIENT INFORMATION

How did you hear about Low T Center? _____

Last Name: _____ First Name: _____ M/I _____

Preferred Name: _____ Date of Birth: _____ Age: _____

SSN: _____ DL# _____ Email:_____

Race & Ethnicity: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White

☐ Hispanic or Latino ☐ Other

_____

Home Phone:_____Cell Phone: _____ Other Phone: _____

*May we send text messages to your cell phone to remind you of appointments and provide other information relevant to your care? ☐ Yes ☐ No

Address:_____City/St/Zip: _____

Employer:_____Position: _____

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 ☐ Decreased mental clarity

Have you been diagnosed with or do you have a family history of:

☐ High Cholesterol ☐ High Blood Pressure ☐ Diabetes ☐ Thyroid Disorders

☐ Heart Attack or Stroke ☐ Cancer ☐ Severe Allergies

When was your last physical or annual wellness examination? _____

What is the main reason for your visit today?_____

Low T Center
Reinventing Men's Healthcare

FINANCIAL RESPONSIBILITY

*****Please give a copy of your Insurance Card to the front desk*****

Insurance Carrier: _____ Group #_____

Member ID: _____

PRIMARY INSURANCE POLICY HOLDER INFORMATION

Last Name: _____ First Name: _____

Relationship: _____ Date of Birth: _____

SSN: _____ Employer: _____

Preferred Phone: _____ (Receive SMS/MMS) Y N {Circle One}

Preferred Email: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____

PRIMARY CARE / REGULAR PHYSICIAN

Name: _____ Phone: _____

SELF-PAY PATIENTS

☐ I have chosen to be self-pay for health care services provided by Low T Center. I have decided to be self-pay even though I may have health insurance that covers some or all of the services I may receive. I waive my right to have a claim submitted to my insurance company on my behalf. I agree to pay for services in the office on the date they are performed.

_____ _____
Patient Signature Date

MEDICARE PART B PATIENTS

☐ Low T Center does not accept assignments under Medicare Part B. I understand that Low T Center will not bill Medicare, and that I cannot appeal coverage issues if Medicare is not billed. I want to be responsible for payment for services that I elect to receive, and I agree that I will not receive services until I have received an estimate of the amount I must pay in connection with those services. I agree to pay for services in the office on the date they are performed.

_____ _____
Patient Signature Date

Low T Center
Reinventing Men's Healthcare

ASSIGNMENT OF HEALTHCARE BENEFITS

Patient Name: _____

Date of Birth: _____

Be it known that, I hereby assign all medical and surgical benefits, to include all past, present, and future medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by my health care provider, regardless of its managed care network participation status. I hereby designate Low T Center (Low-T Physicians Service, P.L..L.C. and its affiliates, collectively "Low T Center") as my agent to release and/or receive all medical information necessary to process my claims. Further, I hereby direct my insurer, plan administrator, fiduciary, and their agents, to release to Low T Center, any and all Plan documents, ERISA information, summary benefit description, insurance policy, and/or settlement information upon written request from Low T Center. In addition to the assignment of the medical benefits and/or insurance reimbursement herein, I also assign and/or convey to Low T Center, any legal or administrative claim, appeal right, claim for equitable relief, or any chose in action arising under ERISA, any group health plan, employee benefits plan, health insurance or other insurance plan, which relates to any services, treatments, therapies, and/or medications I receive from Low T Center. This constitutes an express and knowing assignment of ERISA claims and other legal and/or administrative rights and claims. I intend by this assignment and designation of authorized representative to convey to Low T Center all of my rights to claim the medical benefits related to the services, treatments, therapies, and/or medications provided at Low T Center, including rights to any information, settlement, legal or administrative remedies, and other rights related thereto. Low T Center is designated and given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. Low T Center, as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing. Unless revoked, this assignment is valid for all administrative and judicial reviews under the ACA, ERISA, Medicare and other applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original. I hereby authorize and direct my insurance carrier(s), private insurance and any other health/medical plan to issue payment check(s) and/or electronic payments directly to Low T Center (or its designee) for medical services rendered to me and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance, as may be applicable under my health plan. This assignment shall remain in full force and effect until revoked by me in writing. Written revocation of this assignment shall not affect the authority and rights conveyed herein in relation to any claim for benefits placed prior to the date of such revocation. I hereby authorize Low T Center 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.

I HAVE READ AND FULLY UNDERSTAND THIS ASSIGNMENT OF HEALTHCARE BENEFITS.

_____ _____

Patient Signature Date

NOTICE OF PRIVACY PRACTICES

When it comes to your health and personal identifying information, Low T Center takes your privacy and security seriously. This policy explains your rights and some of our responsibilities to help you understand how we use and manage your personal information. The information subject to his policy includes your “personal identifying information,” which may include data such as your social security number, driver’s license number, biometric data, credit or debit card numbers, as well as "protected health information," which includes information that you share with us treatment, payment, or our operations. You can ask for a paper 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.

We Do Not Sell or Share Your Information with Others

Unless you provide us with permission (for instance, by authorizing the release of your medical records to a third party) we will not release or share your information unless the law requires us to do so. You can ask to see or get an electronic or paper copy of your medical record and other health information at any reasonable time. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee when appropriate. We may say “no” to your request, but we’ll tell you why in writing within 60 days. You can also 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 or our ability to comply with our obligations under the law or to your insurance carrier. However, tf you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information. You can also 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. We will provide you with copies of your medical records at your request, normally within fifteen days of your request, subject to the conditions and charges allowed by your state's laws

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, talk to us. You can tell us how to (i) share information with your family, close friends, or others involved in your care, (ii) share information in a disaster relief situation, (iii) share information through communication instructions that you provide to us (text, email, etc.). If you are not able to tell us your preferences, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. You can ask us to correct health information about you that you think is incorrect or incomplete. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail, email, or text messages to a certain address or telephone number in order to receive information about the services we provide. 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. As a service to our patients, we provide courtesy appointment reminder calls/texts to your cellphone or email account. You may also receive appointment reminders and other information via automated telephone reminders. In some cases, if you use voicemail, we may leave you a voicemail message. The information transmitted can include protected health information. You have the right to opt out of these programs if you do not consent to receiving such calls, texts, emails and reminders. If you do not want to participate, let us know in writing and we will remove you from these programs.

How We Use Your Information

We can use your health information and share it with other professionals who are treating you. We can use and share your health information to run our practice, improve your care, and contact you when necessary. We may use audio or video recording devices to ensure that you have a quality patient experience, or to facilitate treatment. We may also use your personal information to contact you or remind you of appointments, or to inform you about products or services that we offer which may be of interest to you. We can use and share your health information to bill you for services, or to bill and get payment from health plans or other entities In some cases, we are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and

research. We have to meet many conditions in the law before we can share your information for these purposes. The law provides that we can also share health information about you for certain things, like (i) preventing disease, (ii) helping with product recalls, (iii) reporting adverse reactions to medications, (iv) reporting suspected abuse, neglect, or domestic violence, (v) preventing or reducing a serious threat to anyone's health or safety, or (vi) doing research. We may use de-identified statistical or numerical data for purposes of medical research (de-identified means that your identifying information has been removed). We will not use non-de-identified data for research without your permission and consent.

Required Disclosures

Will also share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. We may share your information to respond to requests from a medical examiner, coroner, or funeral director. We may share your information in response to a proper request, for instance, (i) in relation to workers' compensation claims, (ii) for law enforcement purposes or with a law enforcement official, (iii) with health oversight agencies for activities authorized by law, (iv) for special government functions such as military, national security, and presidential protective services, (v) to respond to lawsuits and legal actions, or (vi) in response to a subpoena, or a court or administrative order.

Our Responsibilities

We are required by law to maintain the privacy and security of your personal and protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

File A Complaint

You can complain if you feel we have violated your rights by contacting us as follows: Low T Center, 1920 East Highway 114, Southlake, Texas 76092 ATTN: Privacy Enforcement. Our Privacy Officer is Crystal Nowell, and she can also be reached at crystal.nowell@lowtcenter.com. You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints. We will not retaliate against you for filing a complaint.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site, at www.lowtcenter.com/privacy.

I HAVE READ AND ACKNOWLEDGE RECEIPT OF THE FOREGOING NOTICE OF PRIVACY PRACTICES.

_____ _____

Patient Signature Date

CONSENT FOR DIAGNOSTIC TESTING

Patient Name: _____

MRN: _____ **DOB:** _____

Your Provider has ordered diagnostic laboratory testing to help determine the cause of the symptoms you are experiencing. This testing includes blood testing (full panel) which includes testing the level of hormones in your body, PSA, A1C, lipids, TSH, CMP, and CBC. During this visit you will also complete diagnostic questionairres regarding your quality of life, the AUA Symptom Score, a STOP-BANG test, and your medical history. If your STOP-BANG test is positive, your Provider may order a home sleep test (HST) in addition to required blood testing. These tests will help your Provider better understand the issues that are effecting your body, so that you and your Provider can make informed treatment decisions when you review the results.

Some of the tests above involve venipuncture, commonly referred to as a routine blood draw. Side effects of venipuncture may include mild pain or inflammation. Less common side effects may include bruising, or infection. Some patients may become lightheaded during the procedure, and occasionally, a patient will bleed longer than normal after a venipuncture. Please tell your Provider if you have a clotting disorder, hemophilia, factor V leiden, or have previously experienced issues such as fainting during blood draws. Please tell your Provider if you are taking blood thinners, aspirin, or other drugs.

If your Provider recommends an HST as part of your diagnostic testing, your Provider will provide you with additional paperwork in relation to that test.

Patient:

_____ I consent to the above diagnostic testing, and authorize the medical staff at Low T Center to obtain blood samples as necessary for the purpose of laboratory testing as recommended by my Provider.

_____ _____

Patient Signature Date

AUTHORIZATION
TO RELEASE MEDICAL INFORMATION

CHECK ONE:

(To Authorize Us To Share Your Information With Someone)

_____ 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: _____ Pick-up date: _____

Please release my information by ____ Fax @_____

____ Email* @_____(*not recommended)

(To Authorize Another Physician Or Healthcare Provider To Share Your Information With Us)

_____ I hereby authorize any physicians, nurses, staff, healthcare and medical service providers who receive a copy of this notice, to release and/or disclose the protected health information ("PHI") described below, for the purpose of facilitating healthcare treatment or operations, to: **Low T Center** via Fax @ _____ (45 CFR 164.530(c)).

2. This release covers: (Check one)

_____ Last Labs Only
_____ All records from (date) _____ - to (date)_____
_____ All past, present and future periods.

3. This release includes: (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 Date

DAY 2

CONSENT FOR TREATMENT

Patient Name: _____

MRN: _____ **DOB:** _____

Testosterone Replacement Therapy (TRT) is a therapy utilized in males to treat symptoms associated with the body's failure to produce adequate levels of testosterone. These symptoms may include reduced sexual desire or libido, decreases in energy and motivation, changes in erectile frequency or quality, poor concentration or memory, feelings of irritability, mood disturbances, sleep disturbances, reduced muscle mass, increased body fat, changes in body hair, or gynecomastia (breast enlargement). The objective of therapy is to reduce or eliminate these symptoms by returning the body's usable level of testosterone to a physiologic normal range. Treatment is provided through a regular series of injections, which take place at intervals considering the half-life of testosterone, and your body's reaction to treatment. Alternatives to treatment include implantable pellets, topical substances, or not receiving treatment at all. Many patients combine TRT with other wellness services at Low T Center. These services include treatment for sleep apnea (snoring), thyroid disorders, cholesterol and lipid management, hypertension (high blood pressure), abnormal blood sugar levels (diabetes or pre-diabetes), medically supervised weight management, and other medically appropriate services. Each of these services are designed to maximize your therapeutic results, keep you healthy, and may be covered by your existing health insurance or wellness plan. Your Provider will discuss services which may be right for you, based on your medical history, symptoms, and therapeutic goals.

Risks and Contraindications. Any medical therapy involves risks, and you should discuss each of these with your Provider. It is important to Low T Center that you fully discuss whether TRT therapy is right for you before commencing or continuing treatment. Normally, men who are planning on having children, or have a history of prostate or other cancer, should not participate in TRT. Side effects of testosterone replacement therapy may include acne, breast enlargement, testicular atrophy, mood swings, swelling of the neck or limbs, injection site reactions, or fluid retention. These can be signs of increased red blood cell counts, or other conditions that may require intervention by your Provider. You must also report any drugs or supplements you may be taking. It is important that you provide an updated, accurate, and complete medical history to your Provider before commencing therapy and keep your information current as therapy progresses.

Patients using testosterone should seek medical attention immediately if symptoms of a heart attack or stroke are present. These can include chest pain, shortness of breath, trouble breathing, weakness, numbness, or unusual pain or swelling in one part or one side of the body, difficulty speaking. You should also tell your Provider if you experience persistent erections, increased snoring, or observe changes in skin color as these could be signs of other serious conditions. Please tell your Provider if you are using alcohol, illicit drugs, other steroids, or any of the following drugs: Anisindione, Carfilzomib, Dicumarol, Leflunomide, Iomitapide, Mipomersen, Pexidartinib, Teriflunomide, or Warfarin, as these may negatively interact with the drugs your Provider recommends for you. Each patient's risks can vary depending upon health history and lifestyle. If you have a history of cardiac, urologic, or other medical problems, your Provider may require clearance from your cardiologist, urologist, or other treating physician, before starting, or continuing therapy. You can learn more about potential risks and side effects associated with TRT at www.lowtcenter.com/fda or www.fda.gov/medwatch.

Therapeutic Options. During the initial months of treatment, your Provider will gather important information, such as the results of laboratory testing, medical histories, and make observations relating to your response to treatment. Normally, it takes twelve to sixteen weeks for your body to adjust to changes in hormones. During this initial phase of your therapy, you will receive regular injections as well as personal encounters with your Provider, to facilitate physical examinations, discuss the results of laboratory testing, and progress relating of your therapy.

Optimized Care Option. Once you have achieved a therapeutically stable state, your Provider may recommend Optimized Care. Optimized Care is appropriate for patients who are not experiencing unmanaged side effects and have not exhibited contraindications for further treatment. Under Optimized Care, you will continue to receive regularly scheduled injections, but your Provider will conduct physical examinations and discussion visits on a quarterly, rather than weekly basis. You will still receive regular laboratory testing. All Optimized Care patients must check in utilizing the kiosk or the Low T Center App (available in the AppStore® or through Google Play®), and carefully note any side effects or new issues, as these are important to safely continuing care. During discussion visits, your Provider will discuss appropriate continuing treatment options based on the results of laboratory testing, and your progress on therapy. Before beginning Optimized Care, you should also have had an annual wellness examination (with labs) within the prior twelve months. If you have not had an annual wellness examination, your Provider can schedule one for you.

Remotely Managed Therapy Option. Remotely Managed Therapy (RMT) is available to qualified patients who have achieved a therapeutically stable state with regard to TRT. RMT involves patient-administered injections at home or at a remote location. Before beginning RMT, you must install the Low T Center Patient Mobile App on your smart device. You should also have had an annual wellness examination (with labs) within the prior twelve months. If you have not had an annual wellness examination, your Provider can schedule one for you.

RMT is monitored by your Provider through smart devices, and remote patient encounters. RMT involves the use of these electronic devices to capture and transmit vital signs and other pertinent information relating to treatment. The devices associated with RMT are generally considered secure, however there are privacy risks which relate specifically to these types of remote services and devices. These may range from issues with the device itself, your computer system, or security of the network at your location, to physical security issues relating to your home or other remote location. By consenting to RMT, you are consenting to allow your medical information to be transmitted through electronic devices for the purpose of facilitating treatment. You can learn more about our Privacy Practices and how we protect your data at https://lowtcenter.com/privacy/.

It is critical that you follow your Provider's instructions on proper technique for performing self-injections, as well as the proper storage and disposal of testosterone, syringes, needles, and used containers. Improper storage and disposal can present risks for others, such as family members or children, who could gain access to or be injured by inappropriately stored drugs, or contaminated or used needles, or containers. These risks may include injury, infection, and exposure to testosterone or other blood-borne pathogens, exposure to which could result in injury or death for some persons. Most adverse events caused by self-injecting are the result of improper technique, or failure to follow your Provider's instructions regarding sterile process. For instance, when proper techniques are not followed, it is possible to cause injury to a nerve, blood vessel, or other body part. Improper injection technique may also lead to abscesses or scar tissue formation, which can lead to other serious complications. If you need help with injection technique, contact your Provider. You can also find help online through the Low T Center Patient Mobile App.

Do not attempt to use expired, contaminated, or improperly stored testosterone. Do not self-supplement, over-medicate, deviate from your injection plan, or use testosterone that you have acquired from another source. Do not mix testosterone with "street" performance enhancing drugs, or any medications or supplements that you have not informed your Provider you are taking. Serious adverse reactions can occur, which may include injury or death. Never share, lend, sell or otherwise use testosterone in a manner other than as prescribed by your Provider.

RMT may present additional risks, because of the reduced frequency of in-person physical examinations (which may delay the detection of physical contraindications), and the presence of additional risk-factors which are associated with patient-administered treatments. Even though you consent to receiving remote services, your Provider may determine that it is more appropriate for you to appear in person for an evaluation. For instance, Patients come to the clinic when necessary to meet with their Provider, manage a side-effect of therapy, receive physical examinations, or for necessary laboratory testing. You must stay current on these visits to maintain eligibility for RMT.

Insurance Coverage. Not all insurance covers the various therapeutic options the same way. In-office TRT is normally covered by most health insurance when undertaken in relation to a new or established diagnosis of primary or secondary (or combined) hypogonadism, and laboratory testing demonstrating low blood-serum levels of testosterone. Some, but not all insurers cover RMT. In some cases, you and your physician may decide that treatment for TRT is medically necessary, even when your symptoms or blood test results do not meet the criteria set by your insurance carrier. In these instances, you will be required to pay for services at the time they are rendered.

Bundled Plans. Many patients find that TRT is more cost-effective under the self-pay bundled plans offered by Low T Center. These plans bundle TRT with other wellness services offered at Low T Center. In many cases, these options may result in significant savings, when considering the alternative costs of deductibles, co-pays, co-insurance and the cost of using multiple Providers for different services. You should evaluate each option with your Provider to choose the one that is right for you.

Wellness Programs. Low T Center's wellness programs are designed to help patients realize the therapeutic benefits that come from combining testosterone replacement therapy with an actively managed program of wellness initiatives and medically supervised lifestyle choices. By integrating science and medicine into a program designed specifically for you, your Provider can create a personalized treatment targeted to your body, your health, your lifestyle, and your goals. Low T Center's wellness options begin with an annual wellness examination, laboratory testing, and targeted services which may include (based on your Provider's recommendation) treatment for hypertension, obstructive sleep apnea, cholesterol, triglyceride, and lipid management, management of pre-diabetes or diabetes, hypothyroidism, and medically supervised weight management. Although some services may overlap with primary care services, you should not stop seeing your other physicians for management of other chronic conditions, acute illnesses, injuries, emergencies, and any other types of issues that are not within the scope of Low T Center's wellness services. Based on what you and your Provider decide is appropriate for you, you will be provided with additional information about the specific treatments your Provider recommends, including information about the anticipated therapeutic benefits, risks, and costs of each treatment.

Medication History. Low T Center subscribes to the e-prescribe and pharmaceutical reporting databases in your state. This information is used by physicians and pharmacies to maintain current and accurate listings of medications you may be taking, to help protect against unintended drug interactions or other medication-related issues. As part of this consent, you are authorizing Low T Center to obtain and keep your medication history current during your treatment.

Patient

_____ "I have discussed this form, and my complete past family medical and health history with my Provider. All of my questions concerning the risks, benefits, and alternatives to treatment have been answered. I understand that each patient is different, and there are no guarantees as to results. TRT is not a cure, and if I stop treatment, symptoms may return or worsen. I am providing this consent to begin TRT, under the direction of my Provider.

_____ I have received a copy of Low T Center's Notice of Privacy Practices, and understand that in some instances, smart-devices capable of capturing and transferring my personal data may be used in connection with my therapy. I consent to the use of such devices. I further understand that my Provider may communicate with me utilizing phone calls, email, or text messaging, to remind me of appointments, or to communicate other information, and I consent to receiving these communications. I understand I may obtain a current copy of the Notice of Privacy Practices from the website at any time.

{Check One}

_____ I have completed an annual wellness examination with another physician within the past twelve months, or

_____ I need to schedule an annual wellness examination with my Low T Center Provider."

_____ _____

Patient Signature Date

SPECIFIC CONSENTS

HOME SLEEP TEST
PATIENT RESPONSIBILITY
ACKNOWLEDGEMENT

Patient Name: _____

MRN: _____ **DOB:** _____

Based on your symptoms, medical history, and STOP-BANG test results, your Provider has recommended additional diagnostic testing using a Home Sleep Test (HST). The HST is a take-home remotely monitored instrument that allows a Low T Center board certified sleep physician to review your sleep and breathing patterns to determine whether you are suffering from obstructive sleep apena (OSA). OSA is a life-threatening condition which results in oxygen deprivation, and increases the risk for heart attack or stroke. OSA is characterized by repeated collapse of the airway during sleep and is associated with snoring. Untreated OSA can lead to severe functional impairment, as well as endorgan damage, or death.

SECURITY DEPOSIT: The HST instrument is registered durable medical equipment that is loaned to you, to facilitate the accurate diagnosis of your condition. When you are issued the HST equipment, a $250 security deposit will be placed on your credit card. If you return the HST as instructed (on your next visit, but not more than seven days from the date of issuance), the deposit will be voided. In the event the instrument and all associated parts are not returned in undamaged condition, we may charge some or all the cost of the repairs against the security deposit.

IMPORTANT NOTICE: **You do not own the HST and you must return the instrument as instructed**. Failure to return the HST within fourteen days of the date of issuance will result in your liability for the full cost of the equipment ($3,000), plus any other collection expenses incurred collecting such amounts. In the event you fail to timely return the HST, you authorize us to charge your credit card, in one or more installments in our discretion, up to the full replacement cost of the equipment. Failure to return the HST is considered theft, and may result in additional civil or criminal penalties depending on the laws in your state.

Patient:

"I acknowledge that I am taking a Home Sleep Test Device (HST) to complete a one night, in- home sleep test. I have received instrument - Serial number: _____ on this date: _____. I must return the HST to Low T Center on or before this date: _____.

☐ INSURANCE PATIENT- I understand that Low T Center will bill my insurance under the terms of my insurance policy. I will remain liable for any deductible, copays, coinsurance, or unreturned equipment costs in accordance with the terms of my policy.

☐ SELF-PAY PATIENT- I have elected a self-pay option with regard to the HST, and have paid a payment of $ _____ today, together with the security deposit. I agree to pay all other charges in accordance with the terms of this agreement."

Credit Card To Be Charged As Stated Above:

Cardholder Name: _____

Card Number: _____

Expiration Date: _____

CVV/CSC: _____

"I agree to pay for all charges authorized above in accordance with the terms of the Cardholder Agreement."

Signature of Patient:	Date:

CONSENT FOR TREATMENT OF OBSTRUCTIVE SLEEP APNEA

Patient Name: _____

MRN: _____ **DOB:** _____

Obstructive Sleep Apnea (OSA) is a breathing disorder that occurs during sleep due to narrowing or total closure of the airway, which can significantly reduce oxygen levels in the body. OSA is associated with increased incidence of hypertension, heart disease, atrial fibrillation, stroke, glucose intolerance, and impotence. Untreated OSA can cause daytime sleepiness, high blood pressure, cognitive impairment, loss in work productivity, and increased risk of unsafe operation of automobiles or equipment. Severe, untreated OSA may increase cardiovascular mortality due to the increased risk of heart attack and stroke. Untreated OSA is regarded as a life-threatening condition because of the increase in probability of heart attacks and strokes, especially during sleep.

The most effective treatment for OSA is Continuous Positive Air Pressure (CPAP), which involves a device that helps move air into your airway and keep your airway open through a special type of mask. Rare, but possible side effects of CPAP treatment include mouth dryness, pressure sores from the mask, and mask leak into the eyes or facial area. You may initially experience slight discomfort from the mask and the positive pressure sensation may at first feel foreign. Any issues relating to discomfort usually subside within a few days, as your familiarity with the therapy increases. Other accepted but potentially less effective treatments for OSA include behavioral modification, oral appliances, and surgical interventions. These alternative treatments have other potential side effects associated with them.

Your Provider will explain how CPAP works to treat your OSA. Over the following 2-12 weeks, you will be scheduled for appropriate follow up discussion visits, to ensure you are getting the maximum benefit from therapy. As with any medical intervention, careful monitoring and compliance help ensure success. You will also access to the Low T Center Sleep Helpline (proprietary to Low T Center) and will be contacted on days 1, 3 , 7, 14 and 30 by your personal Low T Center Sleep Coach. Your Coach works with your board certified sleep physician, to make fine adjustments to your equipment and help your physician evaluate the progress of your treatment. Please ask your Coach any questions you may have so you obtain maximum benefit from your therapy.

To remain eligible for this therapy, you must commit to using your CPAP device at least 70% of the time and for a minimum of 4 hours per night. If you are using insurance to help pay for the cost of therapy, you may lose your benefits if you do not meet your insurance carrier's minimum standards for compliance, which means you will be liable for the entire cost of treatment. If you stop or discontinue treatment within the first year, you must return all devices to Low T Center, or otherwise (as required by your insurance plan.)

Obstructive Sleep Apnea is categorized as a serious, life-threatening condition. It is critically important that you follow the instructions of your provider and stay compliant in your consistent use of your CPAP. If you do not follow medical advice, and seek to return your CPAP equipment, we will accept the return of the equipment, however we cannot provide a cash-refund for amounts spent in reference to the equipment or supplies. Once you have returned your equipment, and all supplies, we may bill your insurance carrier for a corrected claim (if applicable). Your insurance carrier will adjudicate the claims for payment in accordance with the requirements of your insurance policy.

PATIENT CONSENT:

_____ I have had an opportunity to discuss my OSA with my provider and have had my questions concerning the risks, benefits, and alternatives to treatment answered. I desire to start CPAP treatment.

_____ I agree that in the event I do not meet minimum compliance requirements, or discontinue treatment with the first year of therapy, I will return all devices and unused supplies to my provider within seven days, or I may be charged for the cost of any unreturned or missing equipment and supplies.

Please circle your preferred form(s) of contact and the time(s) that is most convenient for your Sleep Coach to contact you.

Phone Email Text 10a-12p 12p-3p 3p-6p 6p-7 7p-8p 8p-9p

Automated Re-supply: Some parts of the CPAP equipment are intended to be replaced periodically (mask, hoses, etc.) If you elect to use your health insurance coverage to pay for the cost of treatment, and have met your policy's minimum standards for compliance with your therapy, we can arrange for you to receive the proper re-supply shipments on the correct dates, so that your equipment and supplies are kept current and fully functional, as allowed by the terms of your insurance policy. If you would like this additional convenience, please note your preferred shipping address below. Due to certain restrictions, medical equipment and supplies are unable to be shipped to a PO Box.

*In the unlikely event a particular shipment would result in additional out-of-pocket charges to you, we will contact you prior to shipment and confirm any charges before placing the order. This can happen if you change insurance plans, fail to meet the carrier's minimum use requirements, or in other unplanned situations.

Ship-To Address: _____ City: _____State: _____Zip: _____

Patient Signature: _____ Date: _____

INFORMATION ABOUT THERAPEUTIC PHLEBOTOMY

Patient Name: _____

MRN: _____ **DOB:** _____

Some patients receiving testosterone replacement therapy may develop a condition known as erythrocytosis. Erythrocytosis occurs when your bone marrow makes too many red blood cells. Symptoms of erythrocytosis can include headaches, dizziness, shortness of breath, nosebleeds, increased blood pressure, blurred vision or itching. Having too many red blood cells can increase the risk for blood clots. Blood clots can lead to an increased risk for heart attack or stroke. Some people who live at very high altitudes may have an increased risk of developing erythrocytosis due to environmental factors.

Erythrocytosis is treated by giving blood, or undergoing a procedure known a therapeutic phlebotomy. Therapeutic phlebotomy involves venipuncture, and the removal of blood to reduce the number of red blood cells. Based on the results of your laboratory testing, your Provider has recommended that you receive a therapeutic phlebotomy to reduce your red blood cell count. The alternative to undergoing this procedure is to donate blood at a local bloodbank.

You should not allow erythrocytosis to remain untreated. Failing to follow your Provider's medical advice by declining to (i) donate blood, or (ii) undergo a therapeutic phlebotomy, may lead to serious complications, which could lead to an increased risk of injury or death. Common side effects of therapeutic phlebotomy include soreness or tenderness at the needle insertion site. Although rare, other people may experience temporary dizziness, falling, fainting, bruising, swelling or numbness in the arm, or infection. Talk to your Provider if you have experienced any of these symptoms previously when giving blood or receiving a blood draw.

You should not receive this treatment if you are taking blood thinners, or have hemophilia or another blood clotting disorder. As well, you must talk to your Provider if you have a fever, are currently suffering from an infection, are HIV positive, or have or ever have been exposed to any disease communicable by contact with bodily fluids (AIDS, hepatitis, etc.) Blood drawn for therapeutic purposes will be discarded, and will not be donated or used for transfusion.

After discussing each of these issues with your Provider, you must indicate your consent / non-consent below:

Patient:

"I understand that I have been advised by my Provider to either donate blood, or undergo a therapeutic phlebotomy. After consultation with my Provider, I: {Check one}

[ ] Will donate blood at a local blood bank within the next seven days;

[ ] Consent to receiving a therapeutic phlebotomy in accordance with the recommendation of my Provider;

[ ] **Decline** each of the above options **against medical advice**. I understand that I may be at an enhanced risk for developing further complications, which could include the symptoms discussed above, and may involve an increased risk of heart attack, stroke, or other serious complication."

_____ _____

Patient Signature Date

"I have discussed therapeutic phlebotomy with the above patient, and have explained the risks and benefits of treatment, as well as the potential for other side effects or complications in the event of non-treatment. The above patient has been provided the opportunity to ask questions, and to my knowledge, each of his questions has been answered fully prior to providing this consent."

_____ _____

Provider Signature Date

Low T Center®
Reinventing Men's Healthcare

CONSENT FOR SHINGLES VACCINE

Patient Name: _____

MRN: _____ **DOB:** _____

Shingles vaccination protects against a disease called "shingles," and a related condition called postherpetic neuralgia (PHN), the most common complication from shingles. Shingles is a disease that occurs in persons who have been exposed to chicken pox virus during childhood (about 99% of American adults). Shingles is characterized by a painful skin rash with blisters, which can occur on the body or face.

Shingrix® is a vaccine for shingles. Shingrix is recommended by the Centers for Disease Control for adults over fifty years of age. Shingrix protects persons who have not had shingles, as well as those who have had shingles in the past. Healthy adults should receive two injections of Shingrix, separated by 2 to 6 months, to prevent shingles and the complications from the disease.

Shingrix has been show to reduce the risk of shingles and PHN by more than 90% in persons over the age of fifty. The side effects of the Shingrix vaccine are temporary, and usually last 2 to 3 days. Most people will experience a sore arm with mild or moderate pain after getting Shingrix. Some people may experience redness or swelling at the injection site. Although less common, some people feel tired, or experience muscle pain, headache, shivering, fever, stomach pain, or nausea after receiving the vaccine. Normally, symptoms are mild, and resolve in a couple of days. Some people might experience an allergic reaction to the ingredients in the Shingrix vaccine. These can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness. Prior to receiving the vaccine, you should discuss your complete medical history with your Provider.

If you experience side-effects from the vaccine which do not resolve within three days, you should inform your Provider.

You should not receive the Shingrix vaccine if you have ever had a severe allergic reaction to any component of the vaccine. You should not receive the Shingrix vaccine if you currently have shingles, are sick, or if you have a fever. If you tested negative for immunity to varicella zoster virus after receiving a prior dose of Shingrix, you should receive a vaccine for chickenpox.

Patient:

"This is my consent for the Shingrix shingles vaccine. I have had an opportunity to discuss my complete past medical and health history (including any serious problems and/or injuries) as well as my family history of allergies, diseases and conditions, with my Provider. All of my questions concerning the risks, benefits, and alternatives to vaccination have been answered and I desire to receive the vaccination."

_____ _____

Patient Signature Date

CONSENT FOR ALLERGY TREATMENT

Patient Name: _____

MRN: _____ **DOB:** _____

Allergy immunotherapy is a process by which a patient who is allergic to specific allergens such as (pollens, mold, dust, animal dander, mold spores etc.) is made less sensitive to that specific allergen through injection therapy, thereby resulting in fewer allergic reaction symptoms. The goal of allergy injection therapy is to reduce the occurrence of common symptoms associated with allergic conditions. Allergy immunotherapy does not take the place of avoidance of known allergies, environmental controls, dietary restrictions or the use of medications. Alternatives to allergy treatment include not undergoing allergy injection treatments, avoiding the specific allergen or the use of medications to help with allergy symptoms. Every procedure has limitations, and there are no representations or warranties made regarding the results of allergy injection treatments. Improvement is not often seen immediately and may not be apparent until several treatments have been completed. Treatment may result in a reduction of symptoms, but not an elimination of all symptoms, and in some cases, no improvements may be realized.

Procedure. Your Provider will administer what is called a scratch test, which is generally considered painless. The Provider will test several allergens at the same time. If one of the areas swells up and gets red like a mosquito bite, it means you are allergic to that specific allergen. The test usually takes about 15-20 minutes. Any swelling from a reaction usually goes away within 30 minutes to a few hours. Once the type of allergen is known, small doses of that allergen will be administered by an injection to the patient in an effort to desensitize the patient to that allergen and reduce the types of symptoms they experience from that allergen. In cases of potentially serious allergies, your Provider may prescribe an epinephrine auto-injector for you to carry with you at all times. You must read the label and follow all instructions given by your Provider when using the auto-injector.

Risks. Every procedure involves risk and it is important that you fully understand these and the possible complications associated with allergy injections before you receive treatment. Local reactions to injections can include, burning, itching, swelling, skin redness or discoloration, bleeding or hives. Patients may develop nasal congestion, runny nose, skin rash, headache, vomiting, generalized itching, itching of eyes, ears nose or throat. While not common, more severe complications can include wheezing, shortness of breath, light-headedness, faintness, tightness in the throat or chest, generalized hives, and swelling around the eyes, tongue or throat, cardiac complications, inability to breathe, anaphylactic shock or death.

Contraindications. You should not get this therapy if you are taking beta-blocker medications, or have demonstrated a sensivity to allergy medications. Examples of beta-blocker medications include but are not limited to Inderal, metoprolol, Lopressor, propranolol, Coreg and Toprol. Please advise your Provider about each medication that you are currently taking, and whether you have any allergies to medications.

Observation Period. You should remain in the clinic for 20 minutes following your allergy treatment for observation. Any side effects or reactions you experience should be immediately brought to your Provider's attention. If you have a reaction after leaving the facility, go to the nearest emergency room or call 911.

Costs. Treatment for allergies is typically covered by most health insurance. However, like any treatment, you may elect to pay the costs of treatment out-of-pocket. Allergy medications are custom-compounded in office by your Provider, and if you begin therapy, but fail to commence treatment, you must reimburse the cost of compounding your allergy medicine ($250).

Patient:

_____ "I have read and understand that there may be side effects/complications arising from or related to the treatment as described above, and these have been explained to me by my treating Provider. I have notified my Provider of all medications that I am currently taking and I AM NOT taking a Beta-Blocker medications;

_____ I have been advised to in the clinic for a minimum of 20 minutes following my treatments and will immediately inform my Provider of any side effects I may experience during this period, or after leaving the facility."

_____ _____

Patient Signature Date

SHIP-TO INSTRUCTIONS

Patient Name: _____

MRN: _____ **DOB:** _____

SHIP-TO: _____
Patient name or contact

_____
Patient ship-to address

_____
City, State, Zip

Date: _____

"The above address is a physical address where I can personally receive shipments of medications intended for my personal use. I will immediately notify Low T Center of any changes in the above designated address."

_____
Patient Signature

****FOR INTERNAL USE****

HOME CENTER: _____

VERIFICATION:

"I verify that the above-named patient has demonstrated proficiency in self-injection technique, and has been educated in the proper storage and disposal of testosterone, syringes, needles, and used containers. After consultation, the above-named patient has provided informed consent, and I have verified that the patient's written consent for remotely managed therapy is included in the patient's file. The patient is cleared for participation in remotely managed therapy."

Date: _____

_____
Provider