Patient Registration

First Name: _____ Last Name: _____MI:___

Address: _____

City: _____State: _____Zip Code: _____

E-mail Address:_____

Local Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Birth Date___/____/_____Gender:___M/____F

Can we leave a message on your voicemail? Yes No

Occupation: _____ Employer: _____

Marital Status: ____S____M____D____W Name of Spouse: _____

Spouse Phone: _____ Spouse Employer: _____

Nearest Relative/ Friend: _____Phone: (_____) _____

Please tell us how you heard about us: Internet ___ T.V. ___ Radio ___ Other(specify) _____

If referred please tell us by whom so that we may thank them: _____

Consultations are **exempt and not covered by any insurance carriers.** I acknowledge and understand that I am financially responsible for all services rendered to me at the conclusion of the visit. As a parent or guardian I am financially responsible for any services rendered to the above patient at the conclusion of the visit.

Patient Signature: _____ Date:_____

Parent/ Guardian Signature: _____Date_____

Medical History for Lifestyle Spectrum

Name: _____ Date: _____

Past Medical History (Do you currently have or ever had any of the following):

- ☐ Diabetes
- ☐ Hypertension
- ☐ Elevated Cholesterol
- ☐ Heart Disease
- ☐ Thyroid Disorder
- ☐ GERD/Reflux
- ☐ Sleep Apnea
- ☐ Asthma
- ☐ Emphysema
- ☐ Stroke
- ☐ Seizures
- ☐ Glaucoma
- ☐ Anemia
- ☐ Cancer (Type/Location)_____
- ☐ Arthritis
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Osteoporosis
- ☐ Depression
- ☐ Anxiety
- ☐ Kidney Disease

Women

Are you pregnant, planning to become pregnant, or nursing?

- ☐ Yes
- ☐ No

Men

- ☐ Prostate enlargement
- ☐ Prostatits

List other medical conditions:

_____

_____

Medications:

_____

_____

_____

_____

_____

_____

Surgeries:

_____

_____

_____

Supplements:

_____

_____

_____

Medication Allergies:

_____

_____

_____

Tobacco Use: Age started: _____Amount per day: _____Age quit: _____Currently using amount _____per day/ week

Alcohol Use: Number of drinks per day _____or per week _____or per month _____or Rare/ Never _____

Male Evaluation Sheet

Patient Name:_____ Date:_____

□ Initial Visit □ Follow Up Visit

Symptoms	None	Mild	Moderate	Severe
Lack of Energy				
Decrease in Physical Stamina				
Decrease Desire for Sex				
Decrease in Muscle Mass				
Erection or Potency Problems				
Loss of Early Morning Erection				
Increase in Waist Size				
Weight Gain				
Loss of Motivation				
Increase in Joint/Muscle Pain				
Mood Changes				
Feelings of Depression				
Decrease in memory/concentration				
List Other:				

Men Release of Medical Records Consent Form

****Please fill out this form and send to your physician <u>BEFORE</u> your appointment.**

****It is MANDATORY for Lifestyle Spectrum and Dr. Frank Comstock to have your current PROSTATE RECTAL EXAM REPORT and current PSA REPORT <u>prior to your appointment</u>.**

To: Date: _____

_____
Your Doctor's Name

_____
Their Address

_____

_____
Their Phone Number & Fax

I, _____authorize_____
(Your Name) (Your Doctor's Name)

to release any and all information to include from the **past year only**:

- Prostate Rectal Exam Report
- PSA Report
- Any Hormone Lab Results

*****WE DO NOT ACCEPT MEDICAL RECORDS ON CD's, DVD's, AND FILMS. PLEASE ONLY SEND PAPER COPIES. THANK YOU!**

To:

Frank Comstock, M.D. and all SottoPelle® Physicians
6127 N. La Cholla Blvd. Ste. 175
Tucson, AZ 85741
520.547.2820---Voice
520.547.2822---Fax

_____ _____
Patient Signature Patient Date of Birth

AUTHORIZATION FOR RELEASE OF INFORMATION

According to HIPAA and Governmental rules all patients are asked to sign this release form. This notifies the office that you understand we follow all HIPAA rules by acknowledging this information sheet.

I hereby authorize the use/disclosure of my health information as described below. I understand that this authorization is voluntary. I understand that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed without my prior written authorization except as otherwise provided by law. I understand that a photocopy or fax of this authorization is as valid as the original.

Patient Name: _____ Date of Birth: _____

Person(s)/organizations authorized to receive and use this information:

☐ Insurance Company
☐ Pharmacy (Release of name, date of birth, allergies only)

☐ Significant Other or Family Member: _____

☐ Physician: _____

Information that may be used/disclosed:

- Record of visits (all)
- History & Physical
- Progress Notes
- Lab Reports
- Medication Records
- Consultation Reports
- Problem List
- Statement of Charges/Payments

1. I understand that my health care will not be affected if I do not sign this form.

2. I understand that I may revoke this authorization at any time by notifying the office in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.

3. **I UNDERSTAND THIS IS NOT IN RELATION TO REQUESTING MEDICAL RECORDS FOR MYSELF OR ANOTHER DOCTOR. THERE IS A SEPARATE FORM THAT IS FILLED OUT FOR THAT REQUEST WHICH I CAN OBTAIN BY CONTACTING THE MEDICAL RECORDS DEPARTMENT.**

_____ _____
Signature of Patient or Representative Today's Date

Consent for Hormone Supplementation Therapy

I request and consent to the administration of hormones and authorize that these will be prescribed by Frank Comstock, MD. I acknowledge that there are no guarantees or assurances made with respect to the benefit of hormone supplementation therapy prescribed for me.

I understand that initial blood tests will be performed to establish my baseline hormone levels. I agree to comply with requests for ongoing testing to assure proper monitoring of my hormone levels. I agree to report to the physicians any adverse reaction or problems that might be related to my hormone therapy. I understand that with hormone supplementation there are possible risks and complications if I do not comply with the recommended dosage.

I realize that the advantages of testosterone for men include: a) behavioral changes including decreasing depression, decreasing anxiety and irritability, increasing energy and motivation, stabilizing moods, allowing one to cope better, and enhanced stamina; b) improvement in cognitive function, improving short-term memory and allowing one to stay focused to complete a task; c) physical effects such as decreasing total body fat, increasing lean body mass, increasing muscle mass, increasing bone mass; and, d) sexual benefits such as increasing libido, increasing early morning erections, increasing firmness, and duration of erections.

I realize there are potential concerns with testosterone therapy and they include the possibility of enhancing a current prostate cancer to grow more rapidly. For this reason, a rectal exam and prostate specific antigen blood test is to be done before starting testosterone and will be conducted each year thereafter. If there is any question about possible prostate cancer, I consent to a follow-up with an ultrasound of the prostate gland.

I realize in the past, male athletes have abused testosterone. When they took huge quantities of synthetic testosterone, they may have incurred heart problems and elevated cholesterol. However, low-dose, non-oral, natural testosterone therapy has not been associated with these problems.

The second concern we have with testosterone therapy is that it may increase hemoglobin and hematocrit, or thicken one's blood. This can be reversed through donating blood periodically. This problem can be diagnosed with a blood test. Thus, a complete blood count should be done at least annually.

The final major concern we would have, especially in younger men, is the testosterone administration can suppress the development of sperm and the sperm count could dramatically reduce while a person is on testosterone therapy. However, to date, this appears to be in the majority of men a reversible process, once the testosterone is discontinued, the sperm count is restored, usually in 3-6 months. This is extremely important in younger men taking testosterone therapy. In this early stage, we have encouraged them to produce samples and have them frozen, just in case there is any permanent long-term effect in their situation. We have encouraged any men who are concerned about their fertility in the future to have a semen analysis prior to initiation of testosterone therapy. Currently, testosterone administration is not to be used as a form of male contraception.

I have not been promised or guaranteed any specific benefit from the administration of this therapy. I understand that hormone supplementation for rejuvenation purposes is a new specialty and there are no guarantees with respect to the treatment prescribed.

I understand that the role of the physician is for hormone replacement only. I agree that I am and will be under the care of another physician for all other medical conditions.

I have been informed that insurance companies and Medicare do not pay for hormone supplementation therapy. I therefore agree to pay for all services including laboratory and pharmacy charges myself, with the understanding that I will not be reimbursed by my insurance company.

I have read and understand all of the above consent.

Patient Signature_____ Date_____

Physician Signature_____ Date_____

Acknowledgement of Receipt of Notice of Privacy Practices

By my signature below, I acknowledge that I have received Lifestyle Spectrum, L.L.C. Notice of Privacy Practices.

_____
Name

_____
Signature

_____
Date

Do you give us permission for you to receive our services and product information by e-mail?

□ Yes □ No

Do you give us permission to remind you by telephone of an appointment at home or at work?

□ Yes □ No

If yes please write phone number you prefer_____

This acknowledgement page should be retained by patient's record. If acknowledgment could not be obtained from patient, the reasons must be documented below.

_____
_____
_____
_____
_____
_____