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Client Information

Name:	Today's Date:
Phone Number(s): Cell: Home:	Date of Birth:
Email Address:	Primary Care Doctor:
Referred by:	Social Security Number:
Street Address:	<u>Health Insurance Information</u> Company: Policy (ID) Number:
What are your main reasons for seeking care today? (List most important condition first)	
Occupation:	
Allergies (food and/or drug):	
List ALL prescription medications you are currently taking:	
List ALL vitamin, nutritional or natural products you are currently taking:	

Male Hormone Questionnaire

Circle any of the following conditions you have had previously or currently have and estimated date of diagnoses:			
Thyroid disease	Heart disease		
Breast Disease	Headaches/Migraines		
Benign Prostatic Hyperplasia (BPH)	Lupus/Fibromyalgia /Autoimmune disease		
Blood Clotting Disorder	Osteoporosis		
High blood pressure	Cancer		
High Cholesterol	Smoke Cigarettes: Yes or No		
Is there a family history of:			
Prostate Cancer?	Yes or No	Blood Clots?	Yes or No
Testicular Cancer?	Yes or No	Osteoporosis?	Yes or No
Heart Disease?	Yes or No	Diabetes?	Yes or No

Rate the following if you have experienced any of these symptoms recently?						
0 Lowest – 5 Highest						
Sleep disruption/Insomnia	0	1	2	3	4	5
Decreased libido (sex drive)	0	1	2	3	4	5
Night sweats	0	1	2	3	4	5
Depression	0	1	2	3	4	5
Fatigue	0	1	2	3	4	5
Fluid retention	0	1	2	3	4	5
Male Breast Development	0	1	2	3	4	5

Migraines/headaches	0	1	2	3	4	5
Irritability	0	1	2	3	4	5
Increased Male Pattern Baldness	0	1	2	3	4	5
Nervousness/Anxiety	0	1	2	3	4	5
Decreased quality of orgasm or intercourse	0	1	2	3	4	5
Erectile Dysfunction	0	1	2	3	4	5
Breast tenderness	0	1	2	3	4	5
Dry skin	0	1	2	3	4	5
Mood swings/Short Temper	0	1	2	3	4	5
Crying easily	0	1	2	3	4	5
Weight gain	0	1	2	3	4	5
Short term memory loss	0	1	2	3	4	5
Frequent Urination	0	1	2	3	4	5
Poor concentration	0	1	2	3	4	5
Food cravings	0	1	2	3	4	5
Backaches	0	1	2	3	4	5
Hair loss	0	1	2	3	4	5

Do you have any questions, comments, or concerns regarding Hormone Replacement Therapy (HRT)?

Waiver of Liability:

Being fully informed about your condition and treatment will help you make the decision whether or not to undergo hormone replacement therapy treatment. This disclosure is not meant to alarm you; it is simply an effort to better inform you so that you may give or withhold your consent for this treatment.

I understand that hormone replacement therapy is not an exact science and each and every individual is unique, therefore a treatment that works for one person may not necessarily work for myself. Dr. Willson understands this theory and will work diligently to customize your treatment both subjectively and objectively. Your feedback is instrumental in the success of treatment.

I agree that this constitutes full disclosure and that it supersedes any previous verbal or written disclosures. I certify that I have read and fully understand the above paragraph and that I have had sufficient opportunity for discussion and to ask questions. I consent to this hormone replacement therapy treatment today and for all subsequent treatments.

Patient's Signature: _____ **Date:** _____

Hormone Replacement Therapy Treatment Rates: Initial Consultation, Lab Evaluation and all follow up visits - \$395 due annually on July 1st. Typical follow up sessions are every 4-6 months for 30 minutes. This fee does not include lab work or medications, labs are required to continue treatment and are typically drawn every 6 months but no less than annually.

2014 Hormone Replacement Therapy, Prescription & Procedure Fee Schedule*

(Please Select ONE of the Following Options)

Name: _____ **Due July 1st, 2014**

- Purity Basic: \$395 Annually
~Initial Consultation and Follow Up Appointments.
~Ordering and Evaluation of Labs
~Written Prescriptions*
 •This includes all HRT, Thyroid, Phentermine, Adderall and Accutane Patients
- Purity Premium: ~Testosterone injections - Every 2 Weeks (26 Injections)
~All of the above in the Purity Basic Plan
 \$1600 Annually (Savings of \$485) or \$65 Per Injection + \$395 Annually
- Purity Platinum: ~Sub-dermal Pellet Implantation
~All of the above in the Purity Basic Plan
 Men - \$1625 annually (3 treatments - Savings of \$495) or \$575 Per Treatment + \$395 Annually
 Women - \$1400 annually (4 treatments - Savings of \$495) or \$375 Per Treatment + \$395 Annually
- Purity Individual Office Visit: ~For Monthly Prescriptions such as Phentermine, Adderall & Accutane Only -
In lieu of paying the annual fee and \$95 is due at the conclusion of each visit.
- I no longer wish to use Purity Wellness Center for my Hormone Replacement Therapy or monthly prescription requirements, please refer me to another physician to continue these services.

Add-Ons:

- Labs (Includes 2 Lab Visits to Quest Diagnostics Annually) \$825
All laboratory draws will be billed to and covered by Purity Wellness Center - Designed for patients without health insurance or high deductible insurance.
- Vitamin B12 injections
 Single \$25 26 Injections \$450 (Save \$200) 52 Injections \$850 (Save \$450)

*All prescriptions will be dispensed annually as long as current laboratory results and current patient information is on file.

Please return this invoice with your payment by July 1st, 2014. If payment is not received by July 1st a 10% late fee will be assessed and a disruption in prescriptions may occur. If you have any questions regarding this fee schedule you may call our office at 913-653-3614. Completed forms with credit card information may be securely faxed to 913.839.1437 or emailed to puritywellnesscenter@gmail.com, a receipt will be emailed upon processing.

In Good Health,
Dr. Scott and the PWC Team

Please mark method of payment:

Visa - MasterCard - American Express - Discover Total Amount Authorized \$ _____ Check # _____

Name of Cardholder: _____

Billing Address of Cardholder: _____

Credit Card Number: _____

Expiration Date: _____ CV Code: _____

Cardholder Signature: _____ Date: _____