Stacey Foshee, MD | **Patient Information** | **Please complete all information*

Name _____ (First / Middle / Last) M F (Sex) ____/____/____ (DOB) _____ (Age)

Address _____ (Street Address / City / State / Zip)

Home Phone ( ) - _____ Cell Phone ( ) - _____ Email address _____

Patient Employer _____ SS# _____

Employer's Address _____ (Street Address / City, State / Zip) Employer Phone ( ) -

If Patient is a Minor, Responsible Party

Name _____ Social Security # ___ - ___ - _____

Address _____ (Street Address / City, State / Zip) Phone ( ) -

Employer _____ Occupation _____

Employer Address _____ (Street Address / City, State / Zip) Employer Phone ( ) -

Health Insurance Information

Insurance: _____ Policy Holder : _____ (Policy Holder Name / Soc Sec # / Date of Birth)

Insurance Address: _____ (Street Address / City, State / Zip) Phone ( ) -

Policy # _____ Group # _____

Were you referred to our office? ☐ Yes ☐ No By whom: _____

If not, how did you learn about us? _____

Who should we contact in case of an emergency? _____

_____ (Address / City, State / Zip) Phone ( ) -

Required Authorizations

**Please take a moment to complete all of the following required consents*

Benefits to Physician: I hereby authorize payments directly to Stacey Foshee, MD of the surgical and/or medical benefits. I understand that I am responsible for any portion of my bill not covered by my insurance company within the terms of its contract.

Signed (patient or parent of minor) _____

Release of Information: I hereby authorize release of information necessary for filing my insurance claim or filing a payment review.

Signed (patient or parent of minor) _____

I have received a Notice of Privacy Practices from the office of Stacey Foshee, MD.

Signed _____ Date _____

I have signed the patient consent for use and disclosure of protected health information from the office of Stacey Foshee, MD.

Signed _____ Date _____

HIPAA) I authorize practice/billing company to contact me about my bill by reaching me via (Note: If all boxes are checked "no" we will require prepayment on all services)
Phone: yes ☐ no ☐ Cell phone: yes ☐ no ☐ Work phone: yes ☐ no ☐ Mail: yes☐ no ☐

You <u>may</u> speak with the following person/s about my bill regarding medical services provided:

Name _____ Relationship _____ Phone ( ) -

You <u>may not</u> speak with the following person/s about my bill regarding medical services provided:

Name _____ Relationship _____

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward

Name: _____ DOB: _____ Date: _____

Pharmacy Name: _____ Phone #:_____

Allergies: _____

MEDICATION LIST

MEDICINE	DOSE	FREQUENCY

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Stacey Foshee, MD may use and disclose **protected health information** about me to carry out **treatment, payment and healthcare operations.** Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Foshee reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Practice Privacy Officer at:

Stacey Foshee, M.D.	Stacey L. Foshee, MD, PLLC
Name of Privacy Officer	Practice
PO Box 720631	Norman, OK 73070
Address	City, State, Zip

Telephone
With my consent, Stacey Foshee, MD may call my home or another designated location and leave a message (on voice mail, answering machine or in person) in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations. This may include appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory and other results.

Mail
With my consent, Stacey Foshee, MD may mail to my home or another designated location any items that assist the practice in carrying out treatment, payment and healthcare operations such as appointment reminder cards, correspondence and billing statements.

Email
With my consent, Stacey Foshee, MD may e-mail to my home or another designated location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards, correspondence and billing statements.

I have the right to request that Stacey Foshee, MD restrict the use or disclosure of my protected health information to carry out treatment, payment and healthcare operations. (Please request form.)

I authorize the following individual(s) to call the office on my behalf to verify the status of appointments, treatment plan, medications (as well as pick up prescriptions or drug samples that I have requested) and/or account information. (Please leave blank if you do not authorize another party to access your protected health information.

Name: _____ Relation: _____

Name: _____ Relation: _____

I understand that the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I consent to the use and disclosure of my protected health information to carry out treatment, payment and healthcare operations by Stacey Foshee, MD.

I may revoke my consent in writing except to the extent that the practice has already made disclosures based upon my prior consent. If I do not sign this consent, Stacey Foshee, MD may decline to provide treatment to me.

_____	_____	_____
Print Patient's Name	Signature of Patient **or Legal Guardian*	Date

BHRT CHECKLIST FOR MEN

Name: Date:

Symptom *(please check mark)*	Never	Mild	Moderate	Severe
Decline in general well being				
Joint pain/muscle ache				
Excessive sweating				
Sleep problems				
Increased need for sleep				
Irritability				
Nervousness				
Anxiety				
Depressed mood				
Exhaustion/lacking vitality				
Declining Mental Ability/Focus/Concentration				
Feeling you have passed your peak				
Feeling burned out/hit rock bottom				
Decreased muscle strength				
Weight Gain/Belly Fat/Inability to Lose Weight				
Breast Development				
Shrinking Testicles				
Rapid Hair Loss				
Decrease in beard growth				
New Migraine Headaches				
Decreased desire/libido				
Decreased morning erections				
Decreased ability to perform sexually				
Infrequent or Absent Ejaculations				
No Results from E.D. Medications				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		