



# FoxWest Medical

Your Name:	Last:	First:
Date of Birth/ SS# :	DOB:	SS#:
Address:	Address:	City:
	Apt/Ste.:	State/Zip:
Personal Phone/Cell	Home:	Cell:
Work Phone/Fax	Office:	Fax:
Your Email Address:		Alt:
Who referred you?		Phone:
Insurance Company :		Internal Code:
Address:		City/Zip:
Phones:	Tel:	Fax:
Policy Holder?		ID#:
Credit Card Number	#	Exp Date:

*Please Note:* We are not contracted with any insurance companies, nor do we submit any claim forms.

I authorize and consent to the administration of all diagnostic and therapeutic treatments that may be considered by Laurence S. Fox, D.O., as medically indicated or necessary based upon prior discussion. I am aware that I have the final say so in all aspects of my medical management by Dr. Fox and/or his associates, representatives and appropriate office staff.

\_\_\_\_\_ and dated this \_\_\_\_\_, 20\_\_\_\_.

I authorize the office of Laurence S. Fox, D.O. to charge to my listed credit card fees for services, supplies or missed appointments that I have requested, received or failed to cancel within 24 hours of my appointment. I will be notified of all charges placed on my credit card and will be sent a receipt documenting said charges. This arrangement shall stay in effect unless revoked by written request and/or on an annual basis (calendar year).

\_\_\_\_\_ and dated this \_\_\_\_\_, 20\_\_\_\_.

*Office Staff:* Please place a copy of the insurance card on the back (Both sides of card).

**Place a copy of Drivers License or other photo ID on back. Make sure all information is clear.**

# FoxWest Medical & Aesthetics

## Medical Services Agreement

\_\_\_\_\_ (PATIENT) and FoxWest Medical (Dr. L.S. Fox) hereby enter into this agreement for provision of medical services specified herein ("Services"). Wherefore, in exchange for consideration, the receipt and sufficiency of which the parties hereby acknowledge, the, PATIENT and PHYSICIAN agree as follows:

1. The PATIENT acknowledges and agrees that this agreement has been entered into before the PHYSICIAN has provided the services specified herein to the PATIENT.
2. The FoxWest Medical and its PHYSICIANS are only responsible for the evaluation and prescription of hormone replacement therapy when indicated by appropriate laboratory testing. All laboratory tests can be billed separately by the laboratory performing those services or else the patient may request to pay a discounted fee.
3. The PATIENT acknowledges and agrees that this agreement has not been entered into at a time when the PATIENT is facing an emergency or an urgent health care situation.
4. The services to be provided to the PATIENT consist of performing diagnostic tests and providing assessment of their chemical and hormonal status. All laboratory tests have an interpretation fee and report fee added to their cost.
5. The PATIENT agrees not to submit a health insurance claim (or request the PHYSICIAN to submit a claim on PATIENT'S behalf) under the Social Security Act (MEDICARE) for the services, even if such services are otherwise covered under health insurance or MEDICARE.
6. **The PATIENT agrees to be responsible for the SERVICES.** Although hormone replacement therapy is medically beneficial, insurance companies have not yet accepted this position. At this point in time, neither insurance companies nor MEDICARE will reimburse for preventive care or anti-aging/hormone-balancing replacement therapy. As a result of this, medical records will not be provided to any insurance company or MEDICARE. The United States Department of Health and Human Services, Office of Inspector General take the position that a PHYSICIAN who orders "medically unnecessary" tests may be subject to civil penalties. Because of this, it is the policy of this office not to fill out any insurance benefit claim forms or provide a letter of medical necessity. The Health Insurance and Reform Act of 1997 allows the Federal Government to investigate what they may determine is "health insurance fraud" or any medical treatment not deemed "medically necessary" by the Federal Government. Even though the use of human growth hormone in adults has been approved by the Food and Drug Administration, it has not been recognized by the Federal Government as "medically necessary" and therefore, could, be interpreted as fraudulent.
7. The PATIENT acknowledges that health insurance companies or "Medigap plans" (42 U.S.C., section 1882) will not provided reimbursement, for the SERVICES and that no fee limits (including those specified in 42 U.S.C., Section 1395a', '-1848g) **will** apply to the amounts PHYSICIANS charge for their SERVICES.
8. The PATIENT acknowledges that PATIENT has the right to have services provided by other PHYSICIANS for whom payment may be made under health insurance plans or MEDICARE.
9. By signing this agreement, the PATIENT understands that they are foregoing their rights to receive insurance/MEDICARE benefits for the SERVICES, but that PATIENT is not forfeiting all health insurance benefits for other services from other health insurance/MEDICARE providers.

Patient's Signature	Date:
Physician Signature	Date:
Witness Signature	Date:



# FoxWest Medical & Aesthetics

## Consent to Medical Care and Treatment

**NOTE TO PATIENT:** There are risks involved in any procedure or treatment. It is not possible to guarantee or give assurance of a successful result. It is important that you clearly understand and agree to the planned treatment. You have received specific education regarding the proposed hormonal treatment based upon your assessment. We have reviewed benefits and risks. You have had an opportunity to ask questions and to request additional information.

I authorize \_\_\_\_\_, **D.O.**, and such physicians, associates, assistants and other personnel of the FoxWest Medical chosen by him or her to perform the following:

**Hormonal Assessment and Treatment**, and/or to do any other procedure that in their judgement may be advisable to my well-being, including such procedures as are considered medically advisable to obtain the maximal benefits with the least risks in regards to the above proposed program of hormonal replacement therapy.

**GENERAL RISKS AND COMPLICATIONS:** I am satisfied with my understanding of the more common risks and complications of the treatment, which have been described and I have discussed with the doctor.

**SPECIFIC RISKS AND COMPLICATIONS:** I am satisfied with my understanding of specific risks of this treatment protocol/program as described by the doctor which included: Risks of breast and prostate cancer in association with the use of Testosterone, Estrogens and Growth Hormone. Weight gain, increased muscular mass, decreased body fat, hair growth, hair loss, deepening voice, change in hair color, hypoglycemia, disclosure of latent diabetes, transient fluid retention, carpal tunnel syndrome, transient joint pain, headaches, and death.

**ALTERNATIVE TREATMENT:** I am satisfied with my understanding of alternative treatments and their possible benefits and risks including: **Testosterone Injections, Oral Estrogen/Progesterone replacement, Topical Testosterone, Estrogen, Progesterone replacement or sublingual Testosterone replacement, Isoflavones, Vitamin and mineral replacement.**

**NO TREATMENT:** I am satisfied with my understanding of the possible consequences, outcomes or risks if no treatment is rendered.

**SECOND OPINION:** I have been offered the opportunity to seek a second opinion concerning the proposed treatment from another physician with credentials from the A4M or any physician of my choosing.

**LIMITATION OF MEDICAL CARE:** I understand that the FoxWest Medicals' doctor (Dr. L.S.Fox) is providing a specific hormonal treatment and protocol and that he/she is not taking responsibility for any other aspect of my on going medical health. **My personal physician shall continue to provide all of my standard and continuous medical care. I hereby authorize the doctor to speak directly with my Primary Care physician when medically necessary regarding my past and present medical care and treatment.**

**OTHER QUESTIONS:** I am satisfied with my understanding of the nature of the treatment and all of my additional questions about the treatment have been answered.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time \_\_\_\_\_ AM/PM

Primary Physician: \_\_\_\_\_ Telephone#: \_\_\_\_\_

# FoxWest Medical

## Notice of new HIPAA Guidelines for FoxWest Medical Patients

In general, the HIPPA privacy rule is intended to give further protection for the patient's privacy of medical records and information. This federal rule is now a law as of April 14, 2003. It restricts the dissemination of your personal information to any entity other than those that you specifically indicate by an **in-person information release form**. Additionally, we are restricted in the means by which your own information is provided to YOU. Therefore, please indicate by checking all the applicable, those means by which we can continue to provide you with your periodical medical reports:

I wish to be contacted in the following manner(s):

**Home Phone** \_\_\_\_\_

Leave message with detailed information  
Leave message with call back number

**Mobile Phone** \_\_\_\_\_

Leave message with detailed information  
Leave message with call back number

**E-mail Report** \_\_\_\_\_

Leave Message with detailed information  
Leave message with call back number

**Written Communications** \_\_\_\_\_

Please continue to send to my home

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Patient Signature

Date

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Printed Name and Birth Date

\* Please complete back side\*

WAIVER OF CONFIDENTIALITY AND DESIGNATION OF POWER OF ATTORNEY

# FoxWest Medical

I \_\_\_\_\_, hereby authorize the office of Dr. Scott Fox, his employees, representative or designated representative, or lawyer to act in my behalf in regards to the Institutes, when I am unable to provide a personalized release of information. The FoxWest Medical will keep records of said releases of information in my records and will make these releases available to me upon request.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

## Information released tracking

Date	Requestor	Authorized	Charges	Sent date

**Date:** When request received?

**Requestor:** Who has asked for the information?

**Authorized:** How the patient authorized the release. Must be done in person if they did not sign a limited power of attorney.

Charges

Insurance companies; Life and Medical	\$250.00 they will copy \$350.00 we will copy if asked!
Personal copy for patient	\$25.00 we copy.

**Sent date:** When the document left our office.



# FoxWest Medical & Aesthetics

## Insurance Disclaimer

Dear Patient,

Hormone Restorations is a unique and rapidly growing form of alternative medicine, which is not recognized by the insurance industry. It is viewed as a form of Vanity or Aesthetic Medicine making it a non-reimbursable service.

More so, due to both state and federal issues relating to billing for office visits, and laboratory testing, we have been advised by legal counsel to disassociate from all forms of third party insurance programs. We therefore, are not contracted or participate with any insurance companies and no longer supply the following:

- \_\_\_\_\_ 1. Insurance billing forms.
- \_\_\_\_\_ 2. Standardized Service codes.
- \_\_\_\_\_ 3. Standardized Diagnostic codes.
- \_\_\_\_\_ 4. Transmit any information to any insurance company or their representatives.

Our new **Super Bill** contains pertinent information regarding your office services and purchases. This form was generated for your personal records only although; patients have submitted it to their insurance company with a claim form for reimbursement. **This frequently causes subsequent inquiries by the insurance company to which we do not respond.**

In the event that this office is required to provide additional information, a fee will be charged to you that is equivalent to a time-relative office visit.

I have read the aforementioned and understand the issues presented. In the event that I submit my office SUPER-BILL to the insurance company I agree to pay any additional fees relative to subsequent inquiries.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date.

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# HEALTH HISTORY

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

<b>Name:</b> <i>(Last, First, M.I.)</i>	<input type="checkbox"/> M <input type="checkbox"/> F	<b>DOB</b>
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**Marital Status:**    Single    Partnered    Married    Separated    Divorced    Widowed

<b>Previous or Referring Doctor:</b>	<b>Date of Last Physical Exam:</b>
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**PERSONAL HEALTH HISTORY**

**Childhood Illness:**    Measles    Mumps    Rubella    Chicken Pox    Rheumatic Fever    Polio

<b>Immunizations and Dates:</b>	
<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Influenza	<input type="checkbox"/> MMR
	<i>Measles, Mumps, Rubella</i>

**List Any Medical Problems That Other Doctors Have Diagnosed:**

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**Surgeries:**

Year	Reason	Hospital

**Other Hospitalizations:**

Year	Reason	Hospital

**Have you ever had a blood transfusion?** .....  Yes    No

*Continued on Back Side*

**List Your Prescribed Drugs and Over-the-Counter Drugs, Such as Vitamins and Inhalers:**

Name of Drug	Strength	Frequency Taken

**Allergies to Medications:**

Name of Drug	Reaction You Had

**HEALTH HABITS AND PERSONAL SAFETY**

**Exercise:**       Sedentary (No exercise)       Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)  
 Occasional Vigorous Exercise (i.e., work or recreation less than 4x/week for 30 min.)  
 Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)

**Diet:**      Are you dieting? .....  Yes     No  
 If yes, are you on a physician prescribed medical diet? .....  Yes     No  
 # of meals you eat in an average day? \_\_\_\_\_  
 Rank Salt Intake  Hi     Med     Low    Rank Fat Intake  Hi     Med     Low

**Caffeine:**       None     Coffee     Tea     Cola    # of Cups/Cans Per Day?

**All questions contained in this questionnaire will be kept strictly confidential.**

**Alcohol:**      Do you drink alcohol? .....  Yes     No  
 If yes, what kind? \_\_\_\_\_      How many drinks per week? \_\_\_\_\_

**Tobacco:**      Do you use tobacco? .....  Yes     No  
 Cigarettes - Pks/day       Chew - #/day       Pipe - #/day  
 Cigars - #/day       # of Years       or Year Quit

**All questions contained in this questionnaire will be kept strictly confidential.**

**Drugs:**      Do you currently use recreational or street drugs? .....  Yes     No  
 Have you ever given yourself street drugs with a needle? .....  Yes     No

**Hormonal Therapy:** Are you using **Testosterone** presently? .....  Yes  No  
 If Yes, how much per week \_\_\_\_\_  
 Are you on **Estrogen** treatment for Menopause? .....  Yes  No  
 If Yes how much \_\_\_\_\_  
 Are you on **Progesterone** treatment for Menopause? .....  Yes  No  
 If Yes how much \_\_\_\_\_  
 Have you used any **ANABOLIC STEROID** beside the above .....  Yes  No  
 If Yes which \_\_\_\_\_

**Sex:** Are you sexually active? .....  Yes  No  
 If yes, are you trying for a pregnancy? .....  Yes  No  
 If not trying for a pregnancy, list contraceptive or barrier method used \_\_\_\_\_  
 Any discomfort with intercourse? .....  Yes  No  
 Are you satisfied with your sexual functioning .....  Yes  No

**FAMILY HEALTH HISTORY**

	Age	Age at Death	Significant Health Problems or Cause of Death		Age	Age at Death	Significant Health Problems or Cause of Death
<b>Father</b>				<b>Children</b>	<input type="checkbox"/> M <input type="checkbox"/> F		
<b>Mother</b>					<input type="checkbox"/> M <input type="checkbox"/> F		
<b>Brothers and Sisters</b>	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F			<b>Grandparents (Mother's Side)</b>			
	<input type="checkbox"/> M <input type="checkbox"/> F			<i>Male</i>			
	<input type="checkbox"/> M <input type="checkbox"/> F			<i>Female</i>			
	<input type="checkbox"/> M <input type="checkbox"/> F			<b>Grandparents (Father's Side)</b>			
	<input type="checkbox"/> M <input type="checkbox"/> F			<i>Male</i>			
	<input type="checkbox"/> M <input type="checkbox"/> F			<i>Female</i>			

*Continued on Back Side*

**MENTAL HEALTH**

- Do you feel depressed? .....  Yes  No
- Do you have problems with eating or your appetite? .....  Yes  No
- Do you cry frequently? .....  Yes  No
- Do you have trouble sleeping? .....  Yes  No
- Have you ever been to a counselor? .....  Yes  No

**WOMEN ONLY**

- Age at onset of menstruation:      Date of last menstruation:
- Period every      days. Heavy periods, irregularity, spotting, pain, or discharge?.....  Yes  No
- Number of pregnancies      Number of live births
- Are you pregnant or breastfeeding? .....  Yes  No
  - Have you had a D&C, hysterectomy, or Cesarean section?.....  Yes  No
  - Any urinary tract, bladder, or kidney infections within the last year? .....  Yes  No
  - Any blood in your urine? .....  Yes  No
  - Any problems with control of urination? .....  Yes  No
  - Any hot flashes or sweating at night? .....  Yes  No
  - Do you have menstrual tension, pain, bloating,  
irritability, or other symptoms at or around time of period? .....  Yes  No
  - Experienced any recent breast tenderness, lumps, or nipple discharge? .....  Yes  No
  - Date of last pap smear and rectal exam?

**MEN ONLY**

- Do you usually get up to urinate during the night? .....  Yes  No    If yes, # of times
- Do you feel pain or burning with urination? .....  Yes  No
- Any blood in your urine? .....  Yes  No
- Do you feel burning discharge from penis? .....  Yes  No
- Has the force of your urination decreased? .....  Yes  No
- Have you had any kidney, bladder, or prostate infections within the last 12 months? .....  Yes  No
- Do you have any problems emptying your bladder completely? .....  Yes  No
- Any difficulty with erection or ejaculation? .....  Yes  No
- Any testicle pain or swelling? .....  Yes  No
- Date of last prostate and rectal exam?

**OTHER PROBLEMS**

**Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.**

<input type="checkbox"/> Skin <input type="checkbox"/> Head/Neck <input type="checkbox"/> Ears <input type="checkbox"/> Nose <input type="checkbox"/> Throat <input type="checkbox"/> Lungs <input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Back <input type="checkbox"/> Intestines <input type="checkbox"/> Bladder <input type="checkbox"/> Bowels <input type="checkbox"/> Circulation <b>Recent Changes In:</b> <input type="checkbox"/> Weight	<input type="checkbox"/> Energy Level <input type="checkbox"/> Ability to Sleep <b>Other Pain/Discomfort:</b>
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# FoxWest Medical

## Patient Goals

Dear Patient,

Hormone replacement in an individual with hormone deficiencies may lead to improvement of some medical conditions. The FoxWest practice of **Interventional Endocrinology** does not directly address these overt medical conditions but, only the underlying hormonal deficiency. During the past 10 years, specific results have been so vast and unpredictable that we cannot claim or promises any potential benefits for those medical conditions. What we do recommend is that once hormonal deficiencies are documented that you begin a program of hormone replacement (supplementation) for a period of 3 to 6 months before deciding if there has been any appreciable benefits.

### Treatment Goals

	Decrease percent body fat		Increase lean body mass.
	Improve Muscle Strength		Improve post exercise recovery
	Increase Libido		Improve quality of Skin
	Improve upon erections		Decrease frequency of colds
	Improve on hair condition		Increase physical energy.
	Improve memory		Increase mental energy.
	Increase mental alertness		Improve upon sleep.
	Improve upon mood		Improve on mild depression
			Decrease Menopause symptoms

Name \_\_\_\_\_

Date \_\_\_\_\_

# FoxWest Medical & Aesthetics

## Request for Release of Medical Documents

I, \_\_\_\_\_ authorize the release of the **most recent** medical documents consisting of, but not limited to; Medical Chart Notes, Physical Examination, Laboratory Reports, Consultation Reports, and X-Ray Reports. As per regulations under the BOMQA - Consumer Affairs, these records must be forwarded to the designated recipient (**below**) within 14 calendar days.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name: \_\_\_\_\_

Please send or fax my documents to:

Facility Name/Doctor
Street Address
City, State, Zip
Fax Number
Phone Number

Note to patient: Please maintain a copy of this release form in your files.

# FoxWest Medical

## ANDROPAUSE & MENOPAUSE QUESTIONNAIRE

Testosterone deficiency as seen in both males and females has a pervasive effect on our entire being. Symptoms relative to brain function, sexual function, general metabolic condition and musculoskeletal wellness are inextricable linked to a healthy level of Testosterone. In Anti-Aging Medicine, this age related decline in testosterone is known as Andropause. Replacement can make a difference in how old we feel and how well we perform in our life.

**Name:**

**Date:**

<b>A</b>	<b>Sexual Functions Males</b>	<b>A</b>	<b>Sexual Functions Female</b>
	Decreased early morning erections.		Decreased Libido or sexual desires
	Decreased Libido or sexual desires		Reduction in vaginal sensation during intercourse.
	Decreased fullness of erection		Failure to produce or diminished vaginal lubrication
	Decreased volume of ejaculate or semen		Failure to achieve orgasm
	Decreased strength of orgasm or muscle contractions.		
	Difficulty in maintaining full erection		
	Difficulty in starting erection-or no erection		
<b>B</b>	<b>Mental Functioning</b>	<b>C</b>	<b>Musculoskeletal Conditions</b>
	Spells of mental fatigue or inability to concentrate		Body aches with or without joint and muscle pains
	Tiredness in the afternoon or early evening.		Decline in flexibility and mobility; increased stiffness.
	Feeling burned out		Decrease in muscle size, tone, and strength
	Decrease in mental sharpness, attention, wit.		Decrease in physical stamina.
	Change in creativity or spontaneous new ideas.		Decrease in athletic performance.
	Decrease in initiative or desire to start new projects		Prolonged recovery phase after exercise.
	Decreased interest in hobbies or new activities.		Back pain; neck pain
	Decrease in competitiveness.		Tendency to pull muscles or get leg cramps
	Change in memory function; increased forgetfulness.		Development of Osteoporosis or Inflammatory Arthritis
	Feeling of depression; a sense that work, marriage, or recreational activities have lost significance.		
<b>D</b>	<b>Metabolic Changes</b>	<b>E</b>	<b>or Physical Conditions</b>
	Increase in total cholesterol or triglycerides		Unexplained weight gain, more around the mid-drift
	Increase in LDL cholesterol		<b>Increased fat distribution in breast or hip areas</b>
	Decrease in HDL cholesterol		Increased facial lines and weathering
	Rise in blood sugar level or onset of diabetes		Vertical lines on the upper lip. Rhytides
			Change in visual acuity.
			Decreased night vision.
			Ringing in the ears (Tinnitus)
			Increased symptoms of asthma or emphysema
			Onset of new headaches.
			Shortness of breath with simple activities.
			Lightheadedness or dizzy spells
			Poor circulation in the legs.
			Development of chest pain. or hardening of the arteries.
			Swelling of the legs w/ or w/o increase in varicose veins.

# **Laurence Scott Fox D.O.**

## **Fox West Medical LTD**

### **Email Policy**

Dr. Scott Fox would like to thank you for being his patient. He would also like to assist in streamlining communications. He realizes that many people communicate via email. Currently, due to time constraints email will only be utilized to provide patients with forms. Dr. Fox will not respond to email communications regarding treatments, symptoms, or scheduling. All patient concerns and inquiries must be either in person or via phone. Hopefully, in the future we can utilize the application of email to streamline care.

By signing this form you are saying you understand the above policy. You also are acknowledging that you would like to be emailed forms, or reminders about necessary testing to keep your treatment management up to date. You understand that these forms though they do not contain direct information; the testing can construe certain information. You understand that the emailing of these forms can leave a digital record on your computer, which can be seen by others. Though no patient history is included, inference can occur.

Signature \_\_\_\_\_

Date \_\_\_\_\_



Medical Services Agreement

I, \_\_\_\_\_, understand that should I choose to start hormone replacement therapy, that I must see Dr. Fox on a regular basis for testing and evaluation. This includes being seen in the office. Hormone replacement must be monitored, and office visits with certain diagnostic labs may be required to maintain the prescribing of hormones. I understand that if I am on topical hormone replacement I must be seen every 3 months. I understand that these visits will incur additional fees above and beyond the initial consultation fee.

Signature \_\_\_\_\_ Date \_\_\_\_\_