
2251 N Loop 336 W Ste B
Conroe, Texas 77304
Phone: (936) 441-2673
Fax: (936) 539-9926

**Today's Date:**_____

**Name**:_____
First MI Last

**Address**:_____
Street Apt City State Zip

**Phone #**:_____
Home Cell Work

**E-Mail**: _____

**DOB**:_____ **Age**: _____

**Reason for Visit**:_____

**Referral**:_____

**Primary Insurance Company**:_____

**Insurance Phone#**:_____

**Policy#**:_____ **Group#**:_____

**Policy Holder Name**:_____

**Relationship to Pt:**_____ **DOB**:_____ **Phone#**:_____

**Address (if different from above)**:_____

**Employer**:_____

**Emergency Contact:**

**Name**: _____ **Relationship**: _____

**Phone #1**:_____ **Phone #2:**_____


# NOTIFICATION OF OFFICE APPOINTMENT POLICES

1. When an appointment is made, that time is reserved exclusively for you. We strongly encourage you to keep your scheduled appointment. If you must change your appointment, we require at least 24 hours' notice. Failure to give 24 hours' notice will result in a missed appointment fee of **$50.00** unless unpredictable circumstances occur. A missed initial consultation will be billed at **$100.00**. **This will be strongly enforced.**

2. We do our best to stay on time and request that you be on time also. Any patient who is 15 minutes or more late may be rescheduled at discretion of the doctor. This will be considered a missed appointment.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

***By signing below, you acknowledge that you have received this notice and understand this policy.***

_____ _____

Printed Name Date

_____

Signature

# NO SHOW / CANCELLATION POLICY

Patient Name: _____

I, _____, hereby authorize Core Health & Wellness to charge the credit card listed below in the case I either No Show or Cancel my appointment outside of the cancellation policy window.

Each patient has the opportunity to cancel their appointment within 24 hours. In the case an appointment is on a Monday or following a holiday, the appointment must be cancelled on the last business day prior to their appointment.

**The No-show/cancellation fee for a Wellness/Hormone initial consultation or follow-up appointment with Dr. Villarreal is $50.**

If there is an emergency or last-minute cancellation due to illness, death or any other circumstances that would cause a patient to not attend their appointment, the cancellation policy will be based on a case-by-case basis.

I understand that Core Health & Wellness has enabled this policy in order to give each patient the opportunity to have an appointment each week and not be effected by no-show or late cancelled appointments.

Name on Credit Card: _____

Credit card Number: _____

Exp Date: _____ CV Code: _____ Zip Code: _____

Client Signature: _____ Date: _____

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# INSURANCE DISCLAIMER

Preventative medicine and bio-identical hormone replacement is a unique practice and is considered a form of alternative medicine. Even though the physicians and nurses are board certified as Medical Doctors and RN's or NP's, insurance does not recognize it as necessary medicine BUT is considered like plastic surgery (esthetic medicine) and therefore is not covered by health insurance in most cases.

Core Health & Wellness is not associated with any insurance companies, which means they are not obligated to pay for our services (blood work, consultations, insertions or pellets). We require payment at time of service and, if you choose, we will provide a form to send to your insurance company and a receipt showing that you paid out of pocket. **WE WILL NOT**, however, communicate in any way with insurance companies.

The form and receipt are your responsibility and serve as evidence of your treatment. We will not call, write, pre-certify, or make any contact with your insurance company. Any follow up letters from your insurance to us will be thrown away. If we receive a check from your insurance company, we will not cash it, but instead return it to the sender. Likewise, we will not mail it to you. We will not respond to any letters or calls from your insurance company.

For patients who have access to Health Savings Account, you may pay for your treatment with that credit or debit card. This is the best idea for those patients who have an HSA as an option in their medical coverage.

Name:_____Signature:_____Date: _____


# 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.**

I, _____ , agree while a patient of Core Health & Wellness, I will not take any type of anabolic steroids, testosterone gels, hormone "boosters", prehormones or any additional testosterone supplement not provided by Core Health & Wellness during my treatment plan. At any time, if use of these items is discovered, I understand I may be discharged as a patient of Core Health & Wellness.

_____

Patient Name

_____ _____

Patient Signature Date

_____ _____

Core Health & Wellness Representative Date

CORE HEALTH & WELLNESS

**INFORMED CONSENT FOR TESTOSTERONE THERAPY**

The following information is provided to assist you with making an informed decision regarding the use of testosterone therapy. Please review this information and ask any questions that you may have about it.

1. Testosterone is a controlled medication with risks and benefits. Some potential benefits include:
    - Improvement in energy levels
    - Improves depressive symptoms
    - Improvement in sexual drive
    - Increase muscle mass
    - Decrease in fatigue
    - Increase in bone density
2. Some know or suspected risk in testosterone therapy include (but not limited to)
    - Worsening of cholesterol (in particular, “good” HDL)
    - Raising of hematocrit (blood thickness)
    - Elevated blood pressure
    - Blood clots in the legs, lungs, or brain
    - Edema (water retention or swelling of arms and legs)
    - Increased risk of cardiovascular or cerebrovascular events
    - Elevated levels of calcium in the blood
    - Worsening of sleep apnea
    - Skin-to-skin transference to a partner or child (topical therapy)
    - Skin Irritation
    - Liver dysfunction
    - Interactions with insulin, blood thinners, or corticosteroids
    - Breast tissue growth, swelling, or tenderness
    - Acne and male pattern baldness
    - Reduced testicular size
    - Prostate cancer progression
    - Changes in urinary habits, such as increased difficulty urinating

Testosterone therapy requires close monitoring and regular office visits, and therefore I agree to have the appropriate laboratory testing and office examination as recommended. Testosterone therapy may require donating (therapeutic phlebotomy) if hematocrit levels become too high, and I agree to donate needed. I also understand that I will only be eligible to continue receiving the medication(s) if I am up to date with my office visits, laboratory work, and my needed blood donations.

I certify that I have received and understand this information and had my questions answered. I also understand that I have the option to not take testosterone therapy at any time.

CORE
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**Name:** _____

**DOB:** _____

# PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO DESIGNATED REPRESENTATIVE(S)

**I, _____ give my authorization to release my medical information including results of my laboratory test, ultrasound and/ or other results to my representative(s).**

**Patient Initials**

_____ **My spouse (Name) _____**

_____ **My child (Name) _____**

_____ **Other (Name) _____**

_____ **Personal Representative _____**

_____ **May be left on my voicemail at home _____**

_____ **May be left on my voicemail at work _____**

_____ **May be left on my cell phone _____**

_____ **MAY NOT BE GIVEN TO ANYONE OTHER THAN MYSELF**

_____ _____

**Patient Signature** **Date**

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2251 N Loop 336 W Ste B
Conroe, TX 77304
Tel: (936) 441-2673
Fax: (936) 539-9926

**Name:** _____ **Drug Allergies:** _____

**Preferred Pharmacy:** _____

**Pharmacy Phone:** _____

| Medication | Dose | Frequency | Time AM/PM |
|---|---|---|---|
| | | | |
| | | | |
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CORE HEALTH & WELLNESS

# FEMALE HEALTH ASSESSMENT QUESTIONNAIRE

NAME: _____ EMAIL: _____

TODAY'S DATE: _____ PHONE: _____

Please mark the appropriate box for each symptom you may be experiencing.

| SYMPTOMS | NONE | MILD | MODERATE | SEVERE | VERY SEVERE |
|---|---|---|---|---|---|
| Physical Exhaustion (fatigue, lack of energy, stamina or motivation) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sleep Problems (difficulty falling asleep or sleeping through the night) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Irritability (mood swings, feeling aggressive, angers easily) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Anxiety (feeling overwhelmed, feeling panicky, or feeling nervous) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Decline in drive or interest (loss of "zest for life," feeling down or sad) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Joint and muscular symptoms (joint pain, muscle weakness, poor recovery after exercise) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Difficulties with memory (concentration, finding the right word, or retaining information) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Vaginal dryness or difficulty with sexual intercourse | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sexual Problems (change in desire, activity, orgasm and/or satisfaction) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sweating (night sweats or increased episodes of sweating) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hot Flashes (burst that starts in chest and lasts for short duration) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hair loss, thinning or change in texture of hair | ☐ | ☐ | ☐ | ☐ | ☐ |
| Feeling cold all the time, having cold hands or feet | ☐ | ☐ | ☐ | ☐ | ☐ |
| Headaches or migraines (increase in frequency or intensity) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Weight (difficulty losing weight despite diet/exercise) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Bladder problems (difficulty in urinating, increased need to urinate, incontinence) | ☐ | ☐ | ☐ | ☐ | ☐ |

**Other symptoms or unique health circumstances to take into consideration:**

**Todays Date:** _____

**Patient Name:** _____

**Date of Birth:**_____ **Age:** _____

**Weight/Height:**_____

**Phone:**_____**Address:**_____

**Previous PCP (if any):**_____

**Other Physicians Involved In Your Care:** _____

**Family History (Please include living and deceased, medical issues and age.):**

Father:_____

Mother: _____

Siblings:_____

Grandparents:_____

**Habits:**

Alcohol: Yes ____ No ____ Frequency _____

Tobacco: Yes ____ No ____ Chew Or Smoke?_____ Frequency_____

Caffeine: Yes ____ No ____ Frequency _____

Exercise: Yes ____ No ____ If Yes, How Often? _____

**Social History:**

Work: Employed ____ Unemployed ____ Retired ____ Disabled ____

Current Occupation_____

Marital Status: Married ____ Single ____ Divorced ____ Domestic Partner ____

Children (age):_____

**Past Surgical History (Indicate Date):**

____ None

____ Cataracts_____

____ LASIK_____

____ Tonsillectomy_____

____ Adenoidectomy _____

____ Thyroidectomy_____

____ Bariatric surgery_____

____ Hysterectomy _____

____ Endoscopy _____

____ Colonoscopy_____

____ Hernia _____

____ Spinal Surgery_____

____ Coronary Bypass_____ ____ Tubal Ligation _____

____ Cardiac Stents_____ ____ Bladder Surgery_____

____ Pacemaker_____ ____ Prostate Surgery/Resection _____

____ Heart Valve_____ ____ C-Section _____

____ Gall Bladder_____ ____ Orthopedic/Joints _____

____ Appendectomy_____ ____ Bowel/Stomach Resection _____

____ Hemorrhoidectomy _____ ____ Other _____

**Patient Medical History**

Check Yes or No (Include Date/Explanation)

| **History Of:** | **Yes** | **No** | |
|---|---|---|---|
| Headaches | | | |
| Stroke | | | |
| Seizures | | | |
| Pneumonia | | | |
| Diabetes (Type 1 Or Type 2) | | | |
| Thyroid Disease (Low Or High) | | | |
| Glaucoma | | | |
| Macular Degeneration | | | |
| Hearing Loss | | | |
| High Blood Pressure | | | |
| Blood Clots | | | |
| —Pulmonary Emboli | | | |
| —DVT (Leg Clots) | | | |
| Heart Burn, Reflux | | | |
| Stomach Ulcers | | | |
| Heart Disease | | | |
| —Coronary Disease | | | |
| —MI/Heart Attacks | | | |
| —Congestive Heart Failure | | | |
| —Atrial Fibrillation | | | |

| | | | |
|---|---|---|---|
| —Angina | | | |
| | **Yes** | **No** | |
| —Valve Disorder | | | |
| High Cholesterol | | | |
| Gastrointestinal Bleeding | | | |
| Hepatitis (A, B, C) | | | |
| HIV/ AIDS | | | |
| STD/Herpes | | | |
| Chronic Wounds | | | |
| Cancer (Type) | | | |
| Urinary Tract Infections | | | |
| Incontinence | | | |
| Kidney Stones | | | |
| COPD (Emphysema,Bronchitis) | | | |
| Asthma | | | |
| Depression | | | |
| Bipolar Disorder | | | |
| Anxiety | | | |
| Fibromyalgia | | | |
| Chronic Fatigue Syndrome | | | |
| Arthritis | | | |
| Gout | | | |
| Osteoporosis | | | |
| Prostate Disease | | | |
| Breast Disease | | | |
| Erectile Dysfunction | | | |

Other_____

**For Women:**

Last Pap Smear:_____ Results:_____

Total Pregnancies:_____

Total Miscarriages:_____

Total C-Sections:_____

Hot Flashes Yes ____ No ____ Bleeding After Menopause Yes ____ No ____

Excessive Menstrual Bleeding Yes ____ No ____

Unusual Vaginal Discharge Yes ____ No ____

Menstrual Pain/Cramps Yes ____ No ____

Spotting Between Periods Yes ____ No ____

Age At Onset Of Menstruation: _____

First Day Of Last Menstruation: _____

**Review of Systems (Check Yes or No for Symptoms in Past 6 Months, Circle for symptoms TODAY):**

**Constitutional/Endocrine**

| | | | | | |
|---|---|---|---|---|---|
| ____Yes | ____ No | Fever | ____ Yes | ____ No | Chills |
| ____ Yes | ____ No | Weakness/Fatigue | ____ Yes | ____ No | Weight Loss |
| ____ Yes | ____ No | Weight Gain | ____ Yes | ____ No | Insomnia |
| ____ Yes | ____ No | Snoring | ____ Yes | ____ No | Excessive Thirst |
| ____ Yes | ____ No | Excessive Urination | ____ Yes | ____ No | Cold Or Hot Intolerance |

Other: _____

**HEENT**

| | | | | | |
|---|---|---|---|---|---|
| ____ Yes | ____ No | Sore Throat | ____ Yes | ____ No | Stiff Neck |
| ____ Yes | ____ No | Change In Voice | ____ Yes | ____ No | Sinus Drainage |
| ____ Yes | ____ No | Sinus Headache | ____ Yes | ____ No | Nose Bleeds |
| ____ Yes | ____ No | Earache/Drainage | ____ Yes | ____ No | Hearing Loss |
| ____ Yes | ____ No | Ringing In Ears | ____ Yes | ____ No | Blurred Vision/Loss |
| ____ Yes | ____ No | Glasses/Contacts | ____ Yes | ____ No | Itchy/Watery Eyes |
| ____ Yes | ____ No | Dental Problems | | | |

Other: _____

**Gastrointestinal**

____ Yes ____ No Nausea/Vomiting ____ Yes ____ No Difficulty Swallowing

____ Yes ____ No Hemorrhoids ____ Yes ____ No Diarrhea

____ Yes ____ No Constipation ____ Yes ____ No Bloody Or Black Stools

____ Yes ____ No Abdominal Pain ____ Yes ____ No Heartburn/Indigestion

____ Yes ____ No Frequent Use Of Laxatives

Other: _____

**Urinary**

____ Yes ____ No Incontinence ____ Yes ____ No Pain/Burning With Urination

____ Yes ____ No Blood In Urine ____ Yes ____ No Dark Urine

____ Yes ____ No Urinary Frequency ____ Yes ____ No Slow Starting/Stopping Urine

Other: _____

**Genital/Sex Organs**

____ Yes ____ No Penile Dysfunction ____ Yes ____ No Breast Pain/Discharge/Lump

____ Yes ____ No Testicular Lump/Pain ____ Yes ____ No Painful Intercourse

____ Yes ____ No Lack Of Sexual Drive ____ Yes ____ No Problems With Performance

Other: _____

**Cardiac**

____ Yes ____ No Chest Pain ____ Yes ____ No Palpitation

____ Yes ____ No Irregular Heartbeat ____ Yes ____ No Exercise Intolerance

____ Yes ____ No Leg Swelling

Other: _____

**Respiratory**

____ Yes ____ No Persistent Cough ____ Yes ____ No Coughing Up Blood

____ Yes ____ No Shortness Of Breath ____ Yes ____ No Wheezing

____ Yes ____ No Can’t Breathe Laying Flat

Other: _____

**Skin**

____ Yes ____ No Rashes/Hives ____ Yes ____ No Skin Discoloration

____ Yes ____ No Lesions/Moles/Warts ____ Yes ____ No Ulcers

____ Yes ____ No Itching ____ Yes ____ No Nail Problems

____ Yes ____ No Unusual Hair Loss ____ Yes ____ No Easy Bruising

Other: _____

**Psych**

____ Yes ____ No Depressed Mood ____ Yes ____ No Suicidal Thoughts/Plans

____ Yes ____ No Agitation/Irritability ____ Yes ____ No Insomnia

____ Yes ____ No Anxiety ____ Yes ____ No Frequent Crying Spills

Other: _____

**Musculoskeletal**

____ Yes ____ No Joint Swelling ____ Yes ____ No Joint Pain Or Stiffness

____ Yes ____ No Muscle Weakness ____ Yes ____ No Muscle Spasms/Cramp

____ Yes ____ No Back Pain ____ Yes ____ No Falling

Other: _____

**Neurologic**

____ Yes ____ No Frequent Headache ____ Yes ____ No Seizures

____ Yes ____ No Syncope (Fainting) ____Yes ____ No Limb Weakness

____ Yes ____ No Limb Numbness ____ Yes ____ No Dizziness

____ Yes ____ No Swallowing Difficulty ____ Yes ____ No Balance Issues

____ Yes ____ No Tremors ____ Yes ____ No Rigidity

Other: _____