Low T Center
Reinventing Men's Healthcare

Acknowledgement of Privacy Practices

Receipt of Notice of privacy practices acknowledgement: I have received or reviewed the privacy practice notice for Low T Center and understand the situations in which this practice may need to utilize or release my medical records.

_____ _____
Patient Signature Date

Consent to Obtain Medication History

I authorize the Low T Center to obtain my medication history from the e-prescribing network system. This information will be used by the providers of the Low T Center for the sole purpose of keeping a current and accurate listing of medications.

_____ _____
Patient Signature Date

Consent to Audio or Video Recording Devices

We may use audio or video recording devices to ensure that you have a quality patient experience, or to facilitate treatment. As part of this consent, you give us permission to utilize such audio or video recordings internally for purposes of quality assurance, training and/or safety compliance.

_____ _____
Patient Signature Date

Consent to Have Blood Drawn for Treatment/Testing

I authorize the medical staff at Low T Center to obtain a blood sample for the purpose of running the panel of labs included in our Low T Comprehensive Assessment.

_____ _____
Patient Signature Date

Financial Consent for Comprehensive Assessment

_____ I agree I have not had an Annual Exam in the last 12 months and would like Low T to bill my Insurance for the Comprehensive Assessment which includes the following: Testosterone, PSA, Hemoglobin, CBC, CMP, SHBG, Lipid, TSH and Venipuncture.
_____ I acknowledge I am responsible for any copay/coinsurance or deductible up to 99.00

_____ _____
Patient Signature Date

Low T Center
Reinventing Men's Healthcare

FOR STAFF USE ONLY

Date of Request; Number of Pages:

The undersigned personally verified the capacity of the person requesting said records prior to the release of same.

Patient Charges: $ Staff Initials:

Authorization for Release of Protected Health Information

PATIENT NAME: «PtFullName» DOB: «PtDOB»

CHECK ONE:

_____ I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information (''PHI'') described below to: **Low T Center**

via Fax @ _____ (45 CFR 164.530(c)) **OR**

_____ I hereby authorize my healthcare providers at **Low T Center** to release and/or disclose the protected health information (''PHI'') described below to:

Name: _____ Relationship: _____

Purpose of Release: _____ by _____ Pick-up by _____

_____ Fax @_____

Other: _____ _____ Email* @_____

(*not recommended)

****

2. Authorization for release of PHI covering (check one)

_____ Last Labs Only

_____ All records from (date) _____ - to (date)_____

_____ All past, present and future periods.

3. I hereby authorize the release of the above PHI as follows (check one):

a. ____ my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse); OR

b. ____ my complete health record with the exception of the following information (check appropriate):

_____ Mental health records

_____ Communicable diseases (including HIV and AIDS)

_____ Alcohol/drug abuse treatment

Other (please specify): _____ .

This authorization is valid until revoked by me in writing.

_____, OR _____ _____

Patient Signature Authorized Patient Representative Signature Date

Low T Center®
Reinventing Men's Healthcare

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.
When it comes to your health information, our Providers take your privacy and security seriously. This policy explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record
You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee when appropriate. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Ask us to correct your medical record
You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.

Request confidential communications
You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share
You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information
You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
If you have given someone medical power of attorney (not a durable power of attorney or a general power of attorney) or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint
You can complain if you feel we have violated your if you feel your rights by contacting us as follows: Office of General Counsel, 1901 John McCain, Colleyville, Texas 76034 ATTN: Privacy Enforcement. You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to: (i) Share information with your family, close friends, or others involved in your care, (ii) Share information in a disaster relief situation, (iii) Share information through communication instructions that you provide to us (text, email, etc.) If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

When We Need Your Permission
We never sell your information, however when you give us written permission, we may use your information for marketing purposes.

How do we typically use or share your health information?
We can use your health information and share it with other professionals who are treating you. We can use and share your health information to run our practice, improve your care, and contact you when necessary. We can use and share your health information to bill you for services, or to bill and get payment from health plans or other entities.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.
We can also share health information about you for certain situations such as: (i) Preventing disease, (ii) Helping with product recalls, (iii) Reporting adverse reactions to medications, (iv) Reporting suspected abuse, neglect, or domestic violence, (v) reventing or reducing a serious threat to anyone's health or safety, or (vi) doing research. We may use your personal information to contact you or remind you of appointments when you have requested that we do so.

Required Disclosures
Will also share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. We may share your information to respond to requests from a medical examiner, coroner, or funeral director. We may share your information in response to a proper request, for instance, we can use or share health information about you: (i) For workers' compensation claims, (ii) For law enforcement purposes or with a law enforcement official, (iii) With health oversight agencies for activities authorized by law, (iv) For special government functions such as military, national security, and presidential protective services, (v) To respond to lawsuits and legal actions, (v) In response to a subpoena, or a court or administrative order.

Other Important Information
We will provide you with copies of your medical records at your request within fifteen days of your request, subject to the conditions and charges allowed by your state's laws. We will not attempt to re-identify de-identified protected health information without your permission. If you test positive for HIV, we will not release or cause to become known the positive result of such test without your permission. We may use deidentified statistical or numerical data for purposes of medical research (deidentified means that your identifying information has been removed). We will not use non-deidentified data for research without your permission and consent.

Our Responsibilities
We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.
You may obtain forms for submitting written requests, or obtain additional infromation, by addressing such requests to:

Privacy Officer
c/o Crystal Nowell
1920 East HWY 114
Southlake, Texas 76092
Fax: 817-576-5699

Changes to the Terms of This Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site. This Notice of Privacy Practices applies to the following organizations: Low-T Physicians Service, P.L.L.C, its affiliated providers, and their business associates, Low-T Centers, Inc. and its subsidiaries and affiliates.

PRIMARY INSURANCE POLICY HOLDER INFORMATION (If different than yourself)

*****Please give a copy of your Insurance Card to the front desk*****

Last Name: _____ First Name: _____ M Initial: _____

Relationship: _____ Date of Birth: _____ SSN: _____

Preferred Phone: _____ Employer: _____

Group / Policy #: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____

PRIMARY CARE / REGULAR PHYSICIAN

Name: _____ Phone: _____

Authorization to Release Information

I hereby authorized Low T Center to: (1) release any information necessary to insurance carriers regarding my illness and treatments: (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Low T Center on behalf of myself and/or dependents and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient/Responsible Party Signature Date

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance. If applicable, necessary forms will be completed to file for insurance carrier benefits.

Please select one of the following payment options:

Assignment of Benefits- Insurance

☐ I hereby assign all medical and surgical benefits, to include all past, present, and future medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by my health care provider, regardless of its managed care network participation status. I hereby authorize Low T Center to release all medical information necessary to process my claims. Further, I hereby direct my plan administrator, fiduciary, or insurer, and their agents, to release to Low T Center, any and all Plan documents, ERISA information, summary benefit description, insurance policy, and/or settlement information upon written request from Low T Center. In addition to the assignment of the medical benefits and/or insurance reimbursement herein, I also assign and/or convey to Low T Center, any legal or administrative claim, appeal right, claim for equitable relief, or any chose in action arising under ERISA, any group health plan, employee benefits plan, health insurance or other insurance plan, which relates to any services, treatments, therapies, and/or medications I receive from Low T Center. This constitutes an express and knowing assignment of ERISA claims and other legal and/or administrative rights and claims. I intend by this assignment and designation of authorized representative to convey to Low T Center all of my rights to claim the medical benefits related to the services, treatments, therapies, and/or medications provided by the above-named health care provider, including rights to any information, settlement, legal or administrative remedies, and other rights related thereto. Low T Center is designated and given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. Low T Center, as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original. I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT. I hereby authorize and direct my insurance carrier(s), private insurance and any other health/medical plan to issue payment check(s) directly to Low T Center (or its designee) for medical services rendered to me and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance, as may be applicable under my health plan.

_____ _____

Patient Signature Date

Insurance Waiver and Payment Agreement- Self Pay

☐ I have chosen to be self-pay for health care services provided by Low T Center. I have decided to be self-pay even though I may have health insurance that covers these services and waive my right to have a claim submitted to my insurance company on my behalf. I agree to pay for services in the office on the date they are performed.

_____ _____

Patient Signature Date

Low T Center
Reinventing Men's Healthcare

PATIENT INFORMATION How did you hear about Low T Center? _____

Last Name: «PtLastName» First Name: «PtFirstName» Middle Initial: «PtMiddleName»

Preferred Name: _____Email: _____

Address: _____ City/St/Zip: _____

SSN: _____ Date of Birth: «PtDOB»_____ Age: «PtAgeYears»

Race & Ethnicity: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race

Home Phone: _____ Cell Phone:_____

May we send you a text message reminder the day before your appointment? (Circle one) YES NO

Employer/Title:_____ Work Phone: _____

Work Address: _____ City/St/Zip: _____

Do you desire more children: ☐Yes ☐No

Primary Symptoms: Have you experienced any of the following symptoms?

☐Decreased libido ☐Decreased spontaneous erection ☐Hot flushes ☐Unusual sweating

☐Breast discomfort ☐Gynecomastia ☐Noticeable decrease in testicular size

☐Testes that are less than 2.5cm in length ☐Loss of axillary or pubic hair

Secondary Symptoms: Have you experienced any of the following symptoms?

☐Weight Gain ☐Fatigue ☐Moodiness ☐Decrease mental clarity

Yes/No Questionnaire
Do you currently suffer from this condition?

_____**High Cholesterol**
Is this condition actively being managed by a physician? _____
If not actively managed, are you interested in Low T managing this condition? _____

_____ **High Blood Pressure**
Is this condition actively being managed by a physician? _____
If not actively managed, are you interested in Low T managing this condition? _____

____ **Diabetes**
Is this condition actively being managed by a physician? _____
If not actively managed, are you interested in Low T managing this condition? _____

____ **Weight Gain**
Is this condition actively being managed by a physician? _____
If not actively managed, are you interested in Low T managing this condition? _____

____ **Low Thyroid**
Is this condition actively being managed by a physician? _____
If not actively managed, are you interested in Low T managing this condition? _____