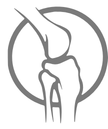

BioTE Intake Form

Name: ______________________ Date of birth: ______________

Address: ______________ City: ____________ State: ____________ Zip: ________

Email: ______________________ Phone Number: ______________________

Emergency Contacts

1. Name: ______________________ Relationship: ______________

Phone number: ______________________

2. Name: ______________________ Relationship: ______________

Phone number: ______________________

Primary Care Physician

Name: ______________________ Phone number: ______________

Insurance

Company: ______________________ Effective Date: ______________________

Group Number: ______________________ Policy Number: ______________________

Please list any drug ALLERGIES that you have and the reaction that occurs

1. ____
2. ____
3. ____
4. ____
5. ____

Brief medical history and any major surgeries:

____

____

____

Social History:

Do you exercise? ☐ YES ☐ NO What type and how often? ________________

Do you consume alcohol? ☐ YES ☐ NO If yes, how much per week? ________________

Do you smoke? ☐ YES ☐ NO If yes, how many per week? ________________

Do you use any non-prescription drugs? ☐ YES ☐ NO If yes, how often, what kind, how many years? ________________

____

Current Medication List:

Medication Name: ________________ Dosage: ________________

Medication Name: ________________ Dosage: ________________

Medication Name: ________________ Dosage: ________________

Medication Name: ________________ Dosage: ________________

Medication Name: ________________ Dosage: ________________

FEMALE BIOTE CONSULT

Are you currently pregnant or trying to conceive?	☐ YES	☐ NO
Have you had a hysterectomy?	☐ YES	☐ NO
Are you still having a menstrual cycle?	☐ YES	☐ NO
Are you on birth control?	☐ YES	☐ NO
Do you smoke?	☐ YES	☐ NO
Are you on any Hormone Replacement Therapy?	☐ YES	☐ NO
Are you currently on Thyroid medication?	☐ YES	☐ NO
Are you on any statins?	☐ YES	☐ NO

Medical History:

History of Breast Cancer?	☐ YES	☐ NO
Epilepsy or Seizures?	☐ YES	☐ NO
Endometriosis or History of Endometriosis?	☐ YES	☐ NO
Fibrocystic Breast Disease?	☐ YES	☐ NO
PCOS (Polycystic Ovary Syndrome)?	☐ YES	☐ NO
History of Leiomyoma or Endometrial Polyps?	☐ YES	☐ NO
Hashimoto's Thyroiditis?	☐ YES	☐ NO

Preexisting Conditions Experienced:

☐ Acne ☐ Breast Tenderness ☐ Facial Hair ☐ Pre-Menstrual Migraines ☐ Hot Flashes

MALE BIOTE CONSULT

Activity Level:

☐ Low ☐ Moderate ☐ Average ☐ High

Currently on Thyroid Medication?	☐ YES	☐ NO
Currently on Statins	☐ YES	☐ NO
Currently on 5a Reductase *(a condition that affects man sexual development before birth or during puberty?)*	☐ YES	☐ NO
Experiencing Symptoms?	☐ YES	☐ NO
Urological Work-Up performed, and OK?	☐ YES	☐ NO
History of Prostate Cancer?	☐ YES	☐ NO
Hashimoto's Thyroiditis?	☐ YES	☐ NO

NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. At Shariar Cohen, MD, A Medical Corporation, we will always keep your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice, and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, reviews of your file by a doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may share your medical information with our business associates, such as our billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. We may also call and remind you of your appointments. If you are not home we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner. We may also create and distribute de-identified health information by moving all references to individually identifiable information.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we do not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any use or disclosure we make with your health information beyond the above normal uses.

You have the right to transfer charts and reports to another practice. There may be a fee associated with this transfer. You have the right to request an amendment or change to your health information. You must make this request in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make changes you request, but we will be happy to include your statement in your file. If we agree on amendment or change, we will not remove nor alter earlier documents, but will add new information.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I acknowledge that I have received, read, and understand the NOTICE OF PRIVACY PRACTICES governed by the Health Insurance Portability and Accountability Act (HIPAA).

Name: ______________________________ Signature: ______________________

Date: ______________________

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Privacy Practices Notice, but could not obtain it for the following reason:

- [ ] Individual refused to sign
- [ ] Communication barriers prohibited acknowledgement.
- [ ] An emergency situation prevented us from obtaining acknowledgment
- [ ] Other (please specify): ______________________________

MEDICAL SERVICES AGREEMENT

Patient's Name:

1. MEDICAL CONSENT: I consent to any medical treatments or procedures which may be performed on an outpatient basis (including emergency treatment or services), which may include, but are not limited to, medications, injections, taking of medical photographs, laboratory procedures, and/or x-ray examinations provided to me under the general and special instructions of the physicians, staff, or other health care providers of SHARIAR COHEN, MD, A Medical Corporation (herein referred to as "SHARIAR COHEN, MD") assisting my care.

2. FINANCIAL AGREEMENT: I understand that all charges are due at the time of service. I agree to pay SHARIAR COHEN, MD for all charges for healthcare services and professional services provided to me by physicians and other healthcare professionals. Acceptable forms of payment include cash, check, Visa, MasterCard, and debit card. If I am a non-insured patient, I agree to pay for my visit in full at the time of service. If SHARIAR COHEN, MD is a participating provider with my insurance company I understand that my co-pay, coinsurance, deductible and/or any outstanding balances are due at the time of service.
I understand that my insurance policy is a contract between myself and my insurance company; SHARIAR COHEN, MD is not involved. In order for SHARIAR COHEN, MD to file claims and accept payments from my insurance company, I understand that I must present current insurance information at each visit and that SHARIAR COHEN, MD will need to verify my health insurance coverage. In the event that SHARIAR COHEN, MD is not able to verify my insurance eligibility and benefits before my visit, I agree to pay for my visit in full at the time of service. A refund will be issued if my insurance pays for the visit. I also understand that I am financially responsible for any services not covered by my insurance company. When my spouse or a financial guarantor signs this agreement, the spouse or the financial guarantor shall be jointly and individually liable with me. Should my account(s) be referred to an attorney or a collection agency for the collection, the undersigned shall pay the actual attorney's fees (including costs) and collections expenses incurred in addition to the other amounts due. Unpaid accounts referred to outside agencies for collection shall bear interest at the current rate per year from the date of referral.

3. INSURANCE AUTHORIZATION AND RELEASE: I request that payment of authorized benefits, including Medicare, and any other government sponsored program, private insurance, and any other health plans be made to SHARIAR COHEN, MD for any services furnished by that provider. To the extent necessary to coordinate my health care or determine liability for payment and to obtain reimbursement for services rendered, I authorize SHARIAR COHEN, MD to disclose portions of or all of my records to any person or corporation which is or may be liable for all or any portion of SHARIAR COHEN, MD's charges,

including but not limited to insurance companies, health care service plans, government agencies, or worker's compensation carriers. I authorize SHARIAR COHEN, MD to act as my agent to help me obtain any required pre-certification as well as acting as my agent to help me obtain payment from my insurance companies. I authorize my insurance companies to give SHARIAR COHEN, MD any information required to fulfill this function. This will remain in effect until revoked in writing. A photocopy of this assignment and release is to be considered as valid as the original.

4. RELEASE OF MEDICAL INFORMATION: I hereby authorize SHARIAR COHEN, MD to release any information in my chart to any practitioner, doctor, hospital, or medical institution to whom I may be referred to assist in my care. Additionally, I authorize any request for medical information from any medical practitioner, doctor, hospital, or medical institution to assist in my care.

5. PERSONAL VALUABLES: SHARIAR COHEN, MD shall not be liable for the loss of or damage to any money, documents, jewelry, glasses, dentures, furs, or other articles of unusual value and shall not be liable for loss or damage to any personal property.

SHARIAR COHEN, MD, A Medical Corporation and the patient or the patient's representative, hereby enters into this agreement. The undersigned certifies that he/she has read and agreed to the foregoing, received a copy, and is the patient, the patient's representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Signature of Patient	Date
or Signature of Patient's Representative & Relationship	Date
Office Representative Signature	Date