LA

LiveAgelessly
8605 S. Eastern Ave Suite C1
Las Vegas, NV 89123

PATIENT INFORMATION

(PLEASE PRINT)

Thank you for choosing LiveAgelessly! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Check appropriate box: ☐Minor ☐Single ☐Engaged ☐Married ☐Separated ☐Divorced ☐Widowed

Gender: ☐Male ☐Female ☐Transgender

Patient Name: ________________________________Birthdate:_________________________________

Home Ph: _________________Cell Ph: ____________________SSN:______________________________

Address: ________________________________City:__________________State:_____Zip: ________

Patient's employer: ______________________Work:_______________Phone:_____________________

Business address: ________________________City: __________________State: _____ Zip: __________

Patient Occupation: ____

Spouse/Partners name: ____

Employer: ___________________________ Work: ________________________Phone:_______________

Whom may we thank for referring you? ____

Person to contact in case of emergency: ____
Relation: ___________________ Phone: ________________

Personal Email ________________________________

Once available, would you like to receive the *LiveAgelessly* newsletter with health-related articles, information about upcoming seminars and workshops, and patient-only special events?

☐Yes ☐No

Dr. Keller and the staff at *LiveAgelessly* are committed to maintaining the privacy of our clients' Protected Health Information, while providing high quality service. Please acknowledge by signing below that you are aware of our NOTICE OF PRIVACY PRACTICES. A photocopy can be furnished to you upon request.

I UNDERSTAND THAT *LIVEAGELESSLY* IS NOT CONTRACTED WITH AND THEREFORE DOES NOT BILL INSURANCE COMPANIES AND THAT I AM RESPONSIBLE FOR ALL FEES AND THAT ALL CHARGES ARE DUE AT THE TIME OF SERVICE.

X____

SIGNATURE **DATE**

LA

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Welcome to LiveAgelessly

We are excited to have you as a patient. It is our promise to try and provide you with the best solution(s) to treat hormonal decline. At LiveAgelessly we want to provide you with bioidentical hormones (BHRT) that are required for your particular needs based upon your symptoms. Using your labs as a road map to guide your therapy, Dr. Keller makes every attempt to get and keep your hormones balanced. She will determine the dosage of BHRT that is best for your individual needs. For some of you this may not be your first time seeing a practitioner for hormone replacement therapy. Please make certain to provide Dr. Keller with information regarding prior use of any hormone replacement therapy. For others this may be your first time seeing someone. Dr. Keller's goal is to not only use hormones, but also to emphasize the importance of proper nutritional supplementation. We recommend only the best nutraceutical grade supplements that have proven themselves both scientifically and clinically in making our patients feel better. **(Please initial at the end of each section).**

Initial Appointments

Please read and complete all patient forms prior to your first appointment. It is highly recommended that you complete your paperwork prior to your appointment. You may fax or email the ***Medical History Questionnaire*** prior to your appointment or bring it to the office on the day of your appointment. If you are unable to complete your paperwork prior to your appointment, we advise that you to arrive a minimum of **30 minutes** prior to your appointment to complete all required paperwork. Dr. Keller does not double book appointments. We prefer that our patients not lose any appointment time filling out paperwork. Paperwork not completed by the beginning of your appointment will need to be completed during your appointment time and your initial consult with Dr. Keller may be shortened or rescheduled. If you have not completed your paperwork **by 5 minutes** past the time of your scheduled appointment, you will need to be rescheduled. You will be charged for the appointment time. If you have many issues that need to be addressed and have a complicated history, it is strongly encouraged that you do one of our packages to give you a full hour for your first consultation. If for some reason your appointment extends over your original scheduled time you may be offered more time, but at the regular non-discounted rate. Extension of an appointment may not be possible if it delays the care to patients with already scheduled appointments. **_______ (Initials)**

Late Appointments

Patient satisfaction is our number one priority. We ask in order to best serve you that you also make us your priority by being on time to all appointments. In return Dr. Keller promises to make every effort to stay on schedule as we value your time as well and understand that you also have a schedule that you follow. If at all possible, we suggest that you arrive 10 minutes early to address administrative needs. If you are late for an appointment, this time will come from your allotted time. For example, if you are 10 minutes late to a 60-minute appointment, you will be charged for the entire 60-minute appointment time allocated to you, even if your actual time with Dr. Keller is 50 minutes. If Dr. Keller is running late due to an unforeseen patient need or an in office or out of office emergency, our office staff will notify you if at all possible and you will receive your full allotted time. If for some unforeseen reason you cannot be seen within a reasonable time frame, you would be contacted and your appointment rescheduled. Please understand that this policy has been put in place so that you not only receive exceptional care, but so that other patients don't make you wait when you have shown on time for your scheduled appointment. **_______ (Initials)**

Cancellations, Missed Appointments, & Rescheduling

At times we may have a waiting list of patients who would like to see Dr. Keller sooner than their scheduled appointment. We are typically booked at least 3 weeks in advance and sometimes longer. We require that all patients give a minimum of 72 hours' notice, to cancel or reschedule appointments. In order to avoid having to increase our fees or shorten appointments and squeeze in more patients, each patient is required to pay for any appointment missed, late or cancelled without the required notification time of 3 business days. We ask that all cancellations or rescheduled appointments be done during regular business hours to allow us ample time to offer the appointment time to another patient. If an appointment is cancelled or rescheduled without required notice, our staff will attempt to fill the appointment. If the appointment does not get filled, you will be charged for the missed/cancelled appointment and you will not be rescheduled until the fee is paid. Please note our staff usually attempts to remind you by phone two days before your appointment; however, we do not guarantee reminder calls and it is your responsibility to remember your appointment time and date. Rescheduling an appointment twice in a row or multiple rescheduling of appointments may result in discharge from the practice, unless if there is a reasonable excuse. Please sign below indicating that you have read and agree to this policy.

____

Signature   Date

New Patient Security Deposit

Unfortunately, it has become necessary for our office to secure first time appointments with a credit card number or personal check. Unlike the standard health care model, Dr. Keller has chosen to see only a limited number of patients in her office per day in order to spend more time with each patient to thoroughly address individual health care needs and goals. In addition, we choose not to charge membership fees as done in other clinics offering similar treatment.

If you are a new patient, you are required to provide a credit card number with expiration date, **which will be charged** $450 when you book your initial consultation. If you cancel less than 72 hours' notice or miss your first appointment there is a non-refundable fee of $150 dollars. All cancellations or rescheduling requests must be made by phone to our office. Messages left on our answering machine or service will be accepted if left at the lunch hour or 72 hours prior to a scheduled appointment. Also, by scheduling a consultation you agree to have your initial lab work completed within 3 weeks from your first appointment.

New patients must read and sign below: I, the cardholder named below, authorize *LiveAgelessly* to use the credit card information provided in the event of cancellation without **72 hours' notice,** or in the event that I, the patient so named below, do not appear at the office of *LiveAgelessly* on the date and time of my scheduled appointment.

____ ___________________________________
Signature Date

Laboratory Testing

Labs are ordered at your first visit. After which all labs are ordered prior to your appointments. Please make every effort to have them done in time so that your treatment plan can be initiated. Once your results are in, someone from LiveAgelessly will call and schedule your appointment. ***We make no guarantees that the labs ordered by our office will be covered by insurance & LiveAgelessly will not correspond with your insurance company or the laboratory. In order to avoid high laboratory fees.*** We also encourage all our patients to know their laboratory benefits before any lab work is drawn. As a courtesy to you, we will email/mail **ONE (1)** lab slip. If you REQUIRE an additional lab order there will be a $25.00 administration fee. **_______ (Initials)**

Prescriptions

Prescriptions are faxed to both compounding pharmacies and/or regular pharmacies, depending upon what is best for each patient. Prescriptions often are covered by insurance companies based upon an individual's health plan coverage. Dr. Keller does not know if an insurance company will cover medications prescribed or how much they will cost. **LiveAgelessly does not check on prescriptions benefits**. This helps to keep our prices affordable. Dr. Keller will not refill or prescribe any maintenance medications. Since these are outside the scope of her practice, you will need to see your Primary Care Physician. For all other prescription refills, please allow 72 business hours for completion. **All prescriptions are faxed to the pharmacy unless if you desire a printed prescription. _______ (Initials)**

Please list the name and cross streets of a regular pharmacy that you would want prescriptions faxed to (i.e. Walgreens Eastern & Sunridge Heights):

____

Insurance Policy

LiveAgelessly is not contracted with any insurance company and does not bill insurance companies. We have a philosophy regarding health care that does not follow the “standard of care” approach for only treating patients that fit a set strict criterion of “sickness” before treatment can be initiated. Our philosophy does not follow the care guidelines put forth by the insurance industry. The goal at *LiveAgelessly* is the prevention of disease, as this is actually easier than waiting until the body completely falls apart before a treatment is initiated. Many people develop symptoms far before a disease process ensues.
If you submit a claim to your insurance company and they request chart notes or any other information that require Dr. Keller to fill out a form, **the fee for handling these issues is $75. _______ (Initials)**

Lab Results, Chart Notes and Release of Records

Dr. Keller will provide you with a copy of your lab results at the time of your appointment. If you would like us to fax your lab results and/or chart notes to another physician, we will gladly do so at **no charge to you**, simply ask our receptionist for a release of records form and we will fax your records. If you want a personal copy of your chart notes there is a $0.60 per page fee and any postage that might be required, if they are being mailed. **_______(Initials)**

Phone Calls/Virtual Appointments

If you have questions or concerns and you cannot wait until your scheduled appointment, feel free to contact our office directly by phone. Telephone consults can also be done via Skype these are what we refer to as *“virtual office visits.”* This gives our patients flexibility if they are out of town and need access to health care. *Virtual office visits* are scheduled on an individual basis depending upon individual needs and what makes the best sense for your health. In other words, some people will require visits that can only be done in the office, as they require physical contact, i.e. a pellet insertion. Fees are not much different than office visits as they are based on time. **______(Initials)**

Email

Dr. Keller prefers to avoid email communication in regards to direct patient care. You are better served by discussing your situation directly with Dr. Keller either in person, by phone or with a virtual appointment. Non-medical related issues with the staff in regard to booking appointments, general information, feedback, etc. will be addressed on a daily basis. In general, emails are an effective way to communicate with the office, but **if you have not heard back from our office staff within 24 hours, please call us.**

Nutraceutical/Supplements

Dr. Keller will make recommendations for supplements. At LiveAgelessly, we offer you high quality supplements that have been proven to help benefit the health of our patients. Our supplement recommendations may change from time to time as we look for the best quality affordable products.

Notice of Privacy Rights

We are committed to maintaining the privacy of our clients' Protected Health Information (PHI), while providing high quality service. In accordance with the HIPAA regulations all patients will receive a full written notice of our client's privacy practices at their first office visit after April 2007 that will explain:

- Your privacy rights regarding your PHI.
- Our obligations concerning the use and disclosure of your PHI.

Indicate below any persons authorized to discuss your PHI with our office. Include the person's name and relationship to yourself. Include a start date and an end date to set restrictions for any individual(s).

Name Relationship Start Date End Date

______________________________ ____________ ____________________

_________________________________ ____________ ____________________

These are your rights as they relate to your PHI. Please initial and acknowledge having read the **Notice of Privacy Practices.** A copy can be furnished to you on request. **_______ (Initials)**

LiveAgelessly

AMS QUESTIONNAIRE

NAME: ______________________________ DOB: _____________ DATE: __________________

Which of the following symptoms apply to you at this time? Please mark the appropriate box for each symptom. For symptoms that do not apply please mark 'NONE"

Symptoms:	NONE	MILD	MODERATE	SERVERE	EXTRMELY SEVERE
SCORE =	1	2	3	4	5
1. Decline in your feeling of general well being (General state of health, subjective feeling) ………………………………	☐	☐	☐	☐	☐
2. Joint pain and muscular ache (lower back pain, Joint pain, pain in a limb, general backache) ………………………	☐	☐	☐	☐	☐
3. Excessive sweating (unexpected/sudden episodes of Sweating, hot flashed independent of strain) ……………	☐	☐	☐	☐	☐
4. Sleep problems (difficulty in falling asleep, difficulty in Sleeping through, waking up early and feeling tired, poor Sleep, sleeplessness) ……………………………………………………………	☐	☐	☐	☐	☐
5. Increased need for sleep, often feeling tired……………………	☐	☐	☐	☐	☐
6. Irritability (feeling aggressive, easily upset about little Things, moody) ……………………………………………	☐	☐	☐	☐	☐
7. Nervousness (inner tension, restlessness, feeling fidgety)	☐	☐	☐	☐	☐
8. Anxiety (feeling panicky) ………………………………...	☐	☐	☐	☐	☐
9. Physical exhaustion/lacking vitality (general decrease in performance, reduced activity, lacking interest in leisure activities, feeling of getting less done or achieving less of having to force one self to undertake activities) ……	☐	☐	☐	☐	☐
10. Decrease in muscular strength (feeling of weakness.) ……….	☐	☐	☐	☐	☐
11. Depressive mood (Feeling down, sad, on the verge of tears, Lack of drive, mood swings, feeling nothing is of any use) …	☐	☐	☐	☐	☐
12. Feeling that you have passed your peak ………………	☐	☐	☐	☐	☐
13. Feeling burnt out, having hit rock bottom………………	☐	☐	☐	☐	☐
14. Decrease in beard growth………………………………….	☐	☐	☐	☐	☐
15. Decrease in ability/frequency to preform sexually…………	☐	☐	☐	☐	☐
16. Decrease in the number or morning erections………………	☐	☐	☐	☐	☐
17. Decrease in sexual desire/libido (lacking please of sex, lacking Desire for sexual intercourse) ……………………………	☐	☐	☐	☐	☐

Do you have any other major symptoms? Yes…………☐ No……☐

If yes, please descirbe:-

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Recent PSA: _______________________________ **Date**_____________ **Digital rectal exam, date:** __________________

PRIOR PSA's DATE:______________________ **Please list all history or prostate problems**____

Baseline____________ **Week4**________________

LiveAgelessly
8605 S. Eastern Ave. Suite #C
Las Vegas, NV 89123
Ph: 702-546-5483
Fax: 702-252-3000

Prostate Exam Waiver For Hormone Therapy

Date: ______________

I, ___________________________ voluntarily choose to undergo hormone therapy. For today's appointment, I have not provided you with a recent prostate report.

___ Due to I wish not to have prostate exams

___ I will provide a copy of my most recent prostate report at my next visit.

___ I have included a copy with my new patient paperwork.

I am aware that the purpose of the prostate exam is the detection of prostate cancer.

I agree that if any prostate cancer develops while on hormone therapy, I release Maria Keller M.D. FACOG from any liability.

Signature:__________________________________

Printed Name:________________________________

8605 S. Eastern Ave. Suite #C
Las Vegas, NV 89123
Ph: 702-546-5483
Fax: 702-252-3000

LAB WORK WAIVER

Labs are ordered at your first visit. After which all labs are ordered prior to your appointments. Please make every effort to have them done in time so that your treatment plan can be initiated. Once your results are in, someone from LiveAgelessly will call and schedule your appointment.

We make no guarantees that the labs ordered by our office will be covered by insurance & LiveAgelessly will not correspond with your insurance company or the laboratory. In order to avoid high laboratory fees, we recommend to check with your health insurance Prior to having labs drawn. We also encourage all our patients to know their laboratory benefits before any lab work is drawn.
*Please keep in mind that there is a $25 fee for all replacement lab slips.

I understand that LiveAgelessly is not responsible for any laboratory expenses and does not guarantee that lab work will be covered by insurance.

Signature: ____ Date: ________________

Patient Name (Print): ____

MALE HEALTH HISTORY

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

Name: | **Age:**
(Last, First, M.I.) **DOB:**

Current Medications, including hormone therapy, vitamins and herbs:

Name of Drug **Strength** **Frequency Taken**

List Any Medical Problems That Other Doctors Have Diagnosed:

□ High Blood Pressure □Thyroid problems □Heart Disease □Diabetes □Asthma/Bronchitis
□Ulcers/Gastritis □Difficulty Urinating □Prostate Problems □Anxiety Disorder □Stroke
□Breast Problems □Depression □Bleeding Disorder □Breast Lump □Jaundice
□Blood Clots □Blood in Urine □Urinary frequency/hesitancy
□Decreased urine flow □Cancer, explain ____
□Hypercholesterolemia □Other: ____

Family History of major medical conditions, list relative and age at diagnosis:

Surgeries: (use separate sheet of paper if needed)

Year **Reason**

Other Hospitalizations:

Year **Reason**

DRUG ALLERGIES:

Health Habits:

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 minutes)
□ Regular Vigorous Exercise (i.e. work or recreation 4x/week for 30 minutes or more)

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

Habits: □ I smoke cigarettes □ I drink more than 10 drinks of alcohol per week □ I am a recovering alcoholic
□ I use or have used marijuana in the last year □ I use cocaine or other illegal drugs

Last PSA (prostate test) Date:________________ Result (check one): __Normal __ Abnormal
Last Rectal exam Date:___________________ Result (check one): __Normal __ Abnormal

Please write down any questions or concerns you may have. (i.e. testosterone, E.D. issues, bladder issues, fecal issues).

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A hormone consultation is provided to review laboratory test results. The purpose of the consultation is for education. It is a single visit, at which time recommendations may be made regarding the best way to balance your hormones. A prescription(s) may be given for hormones or a hormone implant may be recommended. Your health care must be continued with your Family Practice/Internal Medicine doctor. Please share your results with your physician.

A rectal exam by your clinician is required for men prior to starting Testosterone Replacement Therapy (TRT). A urological consultation is required for symptoms or urinary frequency, hesitancy, decreasing stream or blood in urine. A follow up PSA at 3, 6, and 12 months is required for all men started on TRT and biannually thereafter. Testosterone may stimulate an undiagnosed prostate cancer.

In the first year of TRT you will need more frequent labs. This helps to ensure that we are correctly balancing your Testosterone, as each patient's needs are individually addressed. We also want safely monitor your PSA to make certain it is not abnormally increasing. If the PSA increases to high, this could be an indicator for prostate cancer and would prompt an immediate referral to a urologist. Once your hormones are balanced and after the first year of TRT, you are only required to have labs preformed twice a year.

The goals of hormone replacement therapy is to use BioIdentical hormones that will help with restoration of sexual functioning increased libido, increased sense or fell being, improved mental function, prevention of osteoporosis, restoration of muscle strength and minimization of the symptoms of Andropause.

Patient Signature ______________________ Date: ______________________

Erectile Dysfunction can have a major psychological impact on an individual, particularly because of the expectation/pressure in our culture as it relates to sexual relationships. Please answer the following questions honestly.

All questions contained in this questionnaire are strictly confidential.

Mood Questionnaire

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
1. I am more irritable than I used to be	☐	☐	☐	☐	☐
2. At times, I have felt devastated by the Performance of my penis.	☐	☐	☐	☐	☐
3. My erectile dysfunction makes me feel less of a man.	☐	☐	☐	☐	☐
4. I lack masculine confidence	☐	☐	☐	☐	☐
5. I am easily frustrated by little things	☐	☐	☐	☐	☐
6. When I have trouble with my erection, I feel disgusted with my penis.	☐	☐	☐	☐	☐
7. I feel proud of my penis.	☐	☐	☐	☐	☐
8. My erectile dysfunction makes me feel Sexually unattractive	☐	☐	☐	☐	☐
9. When I can't have intercourse, I don't Feel like having sex at all.	☐	☐	☐	☐	☐
10. Sex feels like it is not worth the effort.	☐	☐	☐	☐	☐
11. I avoid sexual opportunities.	☐	☐	☐	☐	☐
12. I don't quite believe my partner(s) when they say they are satisfied with my sexual performance.	☐	☐	☐	☐	☐
13. I am afraid to touch my partner in ways That will make them want to have sex with me.	☐	☐	☐	☐	☐
14. I feel I could not sustain a new relationship because of my erectile dysfunction.	☐	☐	☐	☐	☐
15. My frustration over my erectile dysfunction Has a negative effect on my sexual relationship(s)	☐	☐	☐	☐	☐