LA

LiveAgelessly

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

PATIENT INFORMATION

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:** _____

Patient Occupation: _____

Spouse/Partners name: _____**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 DUEAT THE TIME OF SERVICE.

X_____

SIGNATURE DATE

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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. Since the initial consultation is done virtually. We must have the paperwork in the office **72 hours prior** to your scheduled appointment time. You may fax or email the Medical History Questionnaire prior to your appointment or may bring it to the office the day prior to your appointment. *If you are unable to complete your paperwork prior to your appointment, we will have to reschedule you.* Dr. Keller does not double book appointments. We prefer that our patients not lose any appointment time filling out paperwork. 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. ***Please keep in mind that you have 90 days from your initial appointment to have your bloodwork done and come in for your 6-week follow-up.*** _____ **(Initials)**

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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**

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New Patient Security Deposit

Unfortunately, it has become necessary for our office to secure first time appointments with a credit card number or via cash payment. 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 unless otherwise specified by Dr. Keller.**

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**

Refunds

If you would like a refund, please contact the office immediately. All refunds will be handled appropriately and promptly. If you pay by credit/or debit card you will be refunded less the merchant fees that are processed. We are unable to refund by cash, but we will reimburse via check.

Refunds request can take up to 48 hours to process if receiving a check. Refunds done by credit/debit card will be processed the same day. We cannot refund supplement purchases as they are final sale. We can only refund prepaid visits that are not completed. _____**(Initials)**

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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 recommend paying cash**. 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*. When possible, labs will be ordered electronically, so there is no need for a lab slip. _____ **(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 prescription benefits. Dr. Keller will not be able to refill or prescribe any maintenance medications. Since these are outside the scope of her practice, you will need to see your Primary Care Physician. This helps to keep our prices affordable. **For 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 $25. _____ **(Initials)**

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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 Go To Meeting 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. _____**(Initials)**

Emails

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. Supplement recommendations may change from time to time as we look for the best quality affordable products. *Supplements purchased are non-refundable once they leave the office*. _____**(Initials)**

_____

Signature Printed Name Date

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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**
_____	_____	_____
_____	_____	_____

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)**

_____

Signature Printed Name Date

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FEMALE MEDICAL HISTORY
PLEASE PRINT

Today's Date:_____

Name: _____ **Birthdate:** _____**Age:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

E-Mail Address: _____

Height: _____ **Weight:** _____

			How often and how much?
Do you use tobacco?	☐ Yes	☐ No	_____
Do you use alcohol?	☐ Yes	☐ No	_____
Do you use caffeine?	☐ Yes	☐ No	_____

Doctor's Name **Address:** **Phone:**

_____

_____

_____

_____

Allergies: Please check all that apply. ☐ **I HAVE NO ALLERGIES**

____ **penicillin**	____ morphine	____ dye allergies	____ pet allergies
____ codeine	____ aspirin	____ nitrate allergy	____ seasonal (pollen) allergies
____ sulfa drug	____ food allergies	____ other: _____	

Please describe the allergic reaction you experienced and when it occurred?

_____

_____

_____

_____

_____

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Medical Conditions/Diseases: Please check all that apply to you.

___ Heart disease (example: Congestive Heart Failure)
___ High cholesterol or lipids (examples: Hyperlipidemia)
___ High blood pressure (example: Hypertension)
___ Cancer –list type: _____
___ Ulcers (stomach, esophagus)
___ Thyroid disease
___ Sleep Apnea – do u use CPAP? _____
___ Lung condition (example: asthma, emphysema, COPD)
___ Other: Please list:

___ Blood Clotting Problems
___ Diabetes
___ Arthritis or joint problems
___ Depression
___ Anxiety
___ Headaches/migraines
___ Eye Disease (glaucoma, etc.)
___ Epilepsy

_____

_____

_____

_____

Surgical History:

Check all that apply	Why?	When?
____ Abdominal Hysterectomy, ovaries NOT removed	_____	_____
____ Abdominal Hysterectomy, ovaries removed	_____	_____
____ Vaginal hysterectomy or LAVH, ovaries NOT removed	_____	_____
____ Vaginal hysterectomy or LAVH, ovaries removed	_____	_____
____ Gallbladder	_____	_____

____ Other Please list:

_____

_____

_____

_____

Over-the-counter (OTC) medications:

Please check all products that you use occasionally or regularly. Check all that apply.

___ Pain Reliever
___ Aspirin
___ Acetaminophen (example: Tylenol®)
___ Ibuprofen (example: Motrin IB®)
___ Naproxen (example: Aleve®)
___ Ketoprofen (example: Orudis KT®)
___ Antihistamine (example: Chlor-Trimeton®)
___ Decongestant product (example: Sudafed ®)

___ Sleep aids (exmples: Excedrin PC®, Unisom®, Sominex®, Nytol®)
___ Antidiarrheal (examples: Imodium®, Pepto Bismol®, Kaopectate®)
___ Laxatives/stool softeners (examples: Doxidan®, Correctol®, etc.)
___ Diet aids/weight loss products (example: Dexatril®)
___ Antacids (examples: Maalox®, Mylanta®)
___ Acid blockers (examples: Tagamet HB®, Pepcid C®, Zantac 75®)
___ Other (please list)

_____

_____

_____

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Nutritional/Natural Supplements: Please identify and list the products you are using:

- ☐ vitamins (examples: multiple or single vitamins such as B complex, E, C, beta carotene)
- ☐ minerals (examples: calcium, magnesium, chromium, colloidal minerals, various single minerals)
- ☐ herbs (examples: Ginseng, Ginkgo Biloba, Echinacea, other herbal medicinal teas, tinctures, remedies, etc.)
- ☐ enzymes (examples: digestive formulas, papaya, bromelain, CoEnzyme Q10, etc.)
- ☐ nutrition/protein supplements (examples: shark cartilage, protein powers, amino acids, fish oils, etc.)
- ☐ others (glucosamine, etc.) Please list:

_____

_____

_____

Current Prescription Medications:

Medication Name Dose & how often per day Reason

_____

_____

_____

_____

_____

_____

_____

List Hormones previously taken.

Date Started Date Stopped Why? Side Effects?

_____

_____

_____

_____

Have you ever used oral contraceptives? ☐ No ☐ Yes
Any problems? ☐ No ☐ Yes
If YES, describe any problem(s).

_____

_____

_____

_____

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How many pregnancies have you had? _____ How many children? _____
How many vaginal births? _____ How many cesareans? _____

How many miscarriages? _____ How many abortions? _____

What do you do to avoid a pregnancy? check any that apply

- ☐ Menopausal
- ☐ Tubal Ligation or Essure Tubal Occlusion
- ☐ Vasectomy
- ☐ Mirena IUD, how long? _____
- ☐ Pull and pray
- ☐ Hysterectomy
- ☐ hormonal contraceptive, i.e. pills
- ☐ condoms
- ☐ Copper IUD, how long? _____
- ☐ Other: _____

Do you have a family history of any of the following?

Uterine Cancer	_____	Family member(s)	_____
Ovarian Cancer	_____	Family member(s)	_____
Fibrocystic breast	_____	Family member(s)	_____
Breast Cancer	_____	Family member(s)	_____
Heart Disease	_____	Family member(s)	_____
Osteoporosis	_____	Family member(s)	_____
Colon Cancer	_____	Family member(s)	_____
Thyroid Disease	_____	Family member(s)	_____
Diabetes	_____	Family members(s)	_____

Have you had any of the following tests performed?

Mammogram	☐ No ☐ Yes	Date: _____	Normal result: Yes or No	
PAP Smear	☐ No ☐ Yes	Date: _____	Normal result: Yes or No	
Colonoscopy	☐ No ☐ Yes	Date: _____	Normal result: Yes or No	

Menopausal women only:

How old were you when you had your last menstrual cycle ever? _____

Menstruating women only:

Last menstrual cycle date: _____ Do you consider your cycles to be abnormal cycles?
☐ No ☐ Yes

If Yes, please explain:

_____

_____

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How did you arrive at the decision to consider Bio-Identical Hormone Replacement Therapy?

☐ Doctor ☐ Self ☐ Friend/Family Member ☐ Other: _____

What are your goals with taking BHRT?

_____

_____

_____

_____

_____

Please write down any questions you have about Bio-identical Hormone Replacement Therapy.

_____

_____

_____

_____

_____

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NAME:_____DATE OF BIRTH:_____

MENOPAUSE RATING SCALE (MRS)

Which of the following symptoms apply to you at this time? (*CHECK ONE BOX & CIRCLE APPLICABLE DESCRIPTION*).

Symptoms:	**Rating Scale:**	**NONE**	**MILD**	**MODERATE**	**SEVERE**	**EXTREMELY SEVERE**
1) Hot Flashes: A. Episodes of Sweating B. Night Sweats……		☐	☐	☐	☐	☐
2) Heart Discomfort: A. Unusual Awareness of Heart Beat B. Heart Racing C. Tightness D. Heart Skipping……		☐	☐	☐	☐	☐
3) Sleep Problems: A. Difficulty In Sleeping Through The Night B. Waking Up Early		☐	☐	☐	☐	☐
4) Depressive Mood: A. Feeling Down B. Sad C. On The Verge Of Tears D. Lack of Drive E. Mood Swings……		☐	☐	☐	☐	☐
5) Irritability: A. Feeling Nervous B. Inner Tension C. Feeling Aggressive……		☐	☐	☐	☐	☐
6) Anxiety: A. Inner Restlessness/Anxious B. Panicky……		☐	☐	☐	☐	☐
7) Physical & Mental Exhaustion: A. General Decrease In Performance B. Impaired Memory C. Decrease in Concentration D. Brain Fog/Forgetfulness……		☐	☐	☐	☐	☐
8) Sexual Health: A. Lack Of Desire B. Change In Activity C. Change in Satisfaction……		☐	☐	☐	☐	☐
9) Vaginal Health: A. Dryness Of Vagina B. Difficulty With Intercourse C. Dryness Or Burning During Intercourse……		☐	☐	☐	☐	☐
10) Bladder Problems: A. Difficulty Urinating B. Increased Need To Urinate C. Bladder Incontinence……		☐	☐	☐	☐	☐
11) Musculoskeletal: A. Joint Discomfort/Pain B. Muscular Discomfort/Pain C. Rheumatoid Discomfort/Pain……		☐	☐	☐	☐	☐

****

FOR OFFICE USE ONLY

Please circle which applies to THIS questionnaire. **Baseline** or **Follow-Up**

Baseline ☐ No hormone Therapy ☐ Hormone Therapy (Other than Pellet Therapy) ☐

Testosterone Pellet Dose_____ Date Implanted_____

Additional Hormone Therapy_____ Date Started_____

Pre-Menopausal ☐ Post-Menopausal ☐ Partial Hysterectomy ☐ Total Hysterectomy ☐

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Mammogram Exam Waiver For Hormone Therapy

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

____ Due to I wish not to have mammogram exams

____ I will provide a copy of my most recent mammogram report at my next visit.

____ I have included a copy with my new patient paperwork

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

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

Date: _____

Signature: _____

Printed Name: _____

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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 that you 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):

_____