COPAS HEALTH – REGISTRATION FORM

(PLEASE PRINT)

Today's date:	**PCP:**	
PATIENT INFORMATION		
First Name: ***PLEASE WRITE NAME AS IT APPEARS ON YOUR INSURANCE CARD**	**Last Name:**	**MARITAL STATUS (circle one)** **Single / Married / Divorced / Separated / Widow**
Circle One: **Mr. Ms. Miss Mrs.**	**Date of Birth:**	**Age:**
Address:		**Social Security Number:**
City:	**State / Zip Code:**	**Home or Cell (please circle)**
Occupation:	**Employer:**	**Employer Phone:**
How did you hear about Find You Health?		**Compounding Pharmacy Preference:** **___ Westmoreland New Albany** **___ Westmoreland Sellersburg** **___ Westmoreland Jeffersonville** **___ Compound Care Louisville** **OTHER** **_____**
Email Address:		

Cancellation/ No Show Policy for Office & Lab Appointments

1. **As a courtesy to our office, as well as to those patients who are waiting to be scheduled, please give us at least 24 hours notice of cancellation. If you do not cancel or reschedule your appointment at least 24 hours notice, we will assess a $75.00 "Cancellation/No Show" service charge to your account.**
2. **I understand the "Cancellation/No Show" policy of Copas Health and agree to provide a credit card number, which may be charged $75.00 for any cancellation/no show of a scheduled appointment. I understand that I must cancel or reschedule any appointment at least 24 hours in advance in order to avoid a potential cancellation/no show to the credit card provided.**
3. **Since our office does not accept insurance,** we **do not** provide "superbills" for insurance companies, this involves too many procedure codes and reasons for recommendations which is why we do not participate with what they dictate.
4. **As a courtesy to patients we have PathLabs for in house labs, and they will accept insurance. We are not affiliated with PathLabs, so all billing questions should be addressed to PathLabs.**

5. **DO YOU HAVE INSURANCE THAT YOU WILL BE USING FOR LAB DRAWS WITH PATHLabs. ____YES OR ___ NO**

6. **PLEASE DRINK PLENTY OF FLUIDS AND EAT BEFORE YOUR APPOINTMENT.**
7. **PAYMENT DUE AT TIME OF SERVICE "CHECKS PREFERRED".**

The above information is true to the best of my knowledge. I consent to the use and disclosure of my protected health information for treatment, payment and health care operations as described in Finding Her Health Notice of Privacy Policies (copy available upon request at the front desk). I authorize my insurance benefits to be paid directly to Finding Her Health as indicated on all claims. I understand that I am financially responsible for all fees and balances, regardless of insurance coverage._

_____ _____

Patient/Guardian Signature **Date**

Women's Hormone Questionnaire

Please answer the following questions to the best of your ability. Your answers will help me help you. This is a confidential questionnaire and will not be a part of your medical record.

Are you here for hormone balance?

YES ___ NO___ If yes please complete this form, if no, please give a brief description of why you are here today:

_____

Do you currently, or have you ever, taken hormone replacement? YES ___ NO ___

If yes, please describe what you have taken and if it helped with your symptoms:

_____

In order of importance, please list the three symptoms you would like to address the most:

1. _____
2. _____
3. _____

Have you done anything to alleviate these symptoms? _____

How long have you been feeling the way you are today? _____

When was the last time you felt like yourself? _____

# of Pregnancies: _____ Complications: _____

PLEASE RATE YOUR SYMPTOMS from 1-5 (1 being the least, 5 being the most)

Angry: _____ Anxious: _____ Decreased Libido: _____ Depressed: _____ Difficulty concentrating: _____

Dry Skin: _____ Fatigue: _____ Hair Loss: _____ Headaches: _____ Hot Flashes: _____ Irritability: _____

Memory Concerns: _____ Mood Swings: _____ Night Sweats: _____ Not feeling like yourself: _____

Pain w/intercourse: _____ Pelvic Pain: _____ Sleep Disturbance: ____ Tearful: ____ Urinary Concerns: ____

Vaginal Dryness: _____ Weight Gain: _____ Other: _____

Please describe any other symptoms/concerns even if they sound silly to you, include anything else you feel would be helpful for me to know:_____

_____

The DEA has classified testosterone as a CSA class III drug. Patients receiving any type of class III drug are required by state regulations to be seen by their provider, at a minimum of every **five months**. If you are receiving testosterone as part of your BHRT therapy, it is your responsibility to be seen in the office to be determined by your plan of care and prescription, in order to have your prescription renewed. These visits must be an in office or Telehealth visit.

_____ _____

Patient/Guardian Signature **Date**

Acknowledgement of Receipt of Notice of Privacy Practices

COPAS HEALTH

I hereby acknowledge that I received or read a copy of the medical practice's Notice of Privacy Practices. I further acknowledge that the copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Copas Health endorses, supports and participates in Electronic Health Information Exchange (HIE) as means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other health care providers participate in the HIE network. Using HIE helps your health are providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health-information available to your health care providers through the HIE can also help reduces your cost by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the HIE, or cancel an opt-out choice, at any time.

Please check box if you would like a copy of the Notice of Privacy Practices at this appointment.

Please list preferred method of communication

For Provider call/messages (test results, follow up calls):

Home: _____ Cell: _____

For appointment reminders only:

Home: _____ Cell: _____

Text: _____ Email: _____

Please list the names of any parties we may disclose your protected health to:

_____ _____

_____ _____

PLEASE INITIAL

Ok to leave a message regarding your health on your:

Cell Phone: YES _____ NO_____

Home Phone: YES _____ NO_____

PRINT PATIENT NAME:_____

PATIENT/GUARDIAN SIGNATURE: _____

If signed by guardian, please indicate relationship to patient: _____