Patient History Form

Patient Name: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ Sex: _____

Emergency Contact: _____ Phone Number: _____

How did you hear about us? _____

Occupation: _____

Medical History

Primary Care Provider: _____ Phone: _____

List any medical problems: _____

List all prior hospitalizations, surgeries: _____

List any medications you are taking: _____

Do you have allergies to medication? Yes No If yes, please list: _____

Do you use? Tobacco Alcohol IV Drugs

Which of the following conditions are you currently being treated or have been in the past: (Circle or check any that apply):

Heart Disease, Murmur, Angina, Shortness of breath, Glaucoma, Diabetes, High Cholesterol, Asthma, Seizure, Kidney/Bladder, High Blood Pressure, Stroke Lung Problems, Liver Problems, Low Blood Pressure, Sinus Problems, Headaches, Arthritis, Heartburn, Tonsillitis, Cancer, Depression, Anxiety, Anemia, Ulcers, Thyroid Problems, Seasonal Allergies

Please circle any Family History:
Anemia, Cancer, Diabetes, Glaucoma, Heart Disease, Hight Blood Pressure, Stroke, HIV Disease/Aids, Mental Illness, Depression, Other: _____

MALES: ADAM Questionnaire:

Do you have a decrease in libido?	Yes ____	No _____
Do you have a decrease in energy?	Yes ____	No _____
Do you have a decrease in strength and endurance?	Yes ____	No _____
Have you lost height?	Yes ____	No _____
Have you noticed a decreased “enjoyment of life”?	Yes ____	No _____
Are you sad or grumpy?	Yes ____	No _____
Any difficulty with erection or ejaculation?	Yes ____	No _____
Have you noticed a decrease in your ability to play sports?	Yes ____	No _____
Are you falling asleep after dinner?	Yes ____	No _____
Has there been a recent deterioration in your work performance?	Yes ____	No _____

Date of Colonoscopy: _____
Date of last prostate and rectal exam: _____

FEMALES: GYNECOLOGICAL HISTORY AND SYMPTOMS

How many times have you been pregnant? _____ Date of last Pap Smear: _____

Have you had an abnormal Pap Smear? Yes ____ No _____ Diagnosis: _____

Date of Last Mammogram: _____ Results: _____

Have you ever had a breast biopsy: Yes _____ No _____ Biopsy Result: _____

When was your last menstrual period? _____ Duration: _____

Are they regular in amount? Yes _____ No _____

FEMALE SYMPTOMS OF HORMONE IMBALANCE

Hot Flashes:	Yes ____	No_____	Night sweats:	Yes _____	No _____
Mood swings:	Yes ____	No _____	Depression:	Yes _____	No _____
Weight gain:	Yes ____	No _____	Trouble sleep:	Yes _____	No _____
Mental fog:	Yes ____	No _____	Dry Skin:	Yes _____	No _____
Pain during intercourse:	Yes ____	No _____	Vaginal dryness:	Yes ____	No _____
Heavy vaginal bleeding:	Yes ____	No _____	Breast tenderness:	Yes ____	No_____
Less interest in sex:	Yes ____	No _____	Hair loss on head:	Yes ____	No _____
Acne: Yes _____	No ____	Excessive hair on face/arms:		Yes ____	No _____

Other:_____

CONSENT FOR TREATMENT: I, the patient named above, do request and consent to have **ELIV8 MD,** and their employees, evaluate and treat the above patient for medical complaint and illnesses. This includes, but is not limited to, taking of medical information, evaluation by physical examination, obtaining of bodily fluids for laboratory testing, the administration of medications for treatment, and any other treatment or evaluation that may be necessary. If, at any time, I do not wish to have these services rendered, I may state so and they will not be provided, but an AMA form may need to be signed by the patient. All my Information will remain confidential. I acknowledge that I have been offered a copy of ELIV8 MD, Notice of Privacy Practices.

CONSENT FOR TEST INFORMATION: ☐ by checking this box I agree to be contacted by phone and voicemail may be left, and/or by email by our staff regarding your medical treatment and information.

Phone #: _____ Email: _____

By signing below I hereby certify that to the best of my knowledge all Information I have furnished on this form is complete, true, and accurate, I also understand this agreement between ELIV8 MD.

Patient Name: _____

Patient Signature: _____

Date: _____

ELIV8 MD

WWW.ELIV8MD.COM

I,_____, fully understand that ELIV8 MD - Louisville does not provide prescriptions, direct/indirect, or provide any access to controlled substances referred to as “anabolic steroids.”

ELIV8 MD — Louisville does provide treatments with peptides, sex hormones, and other prescribed medications, including controlled substance testosterone, however no substances considered or known to be otherwise anabolic steroids. Initial: _____

ELIV8 MD — Louisville will offer you treatment with their provider and prescriptions however if you use anabolic steroids, you must get them from other providers.

Initial: _____

ELIV8 MD — Louisville and its owner, its staff and its Medical Director, Michael Iannotti, MD, has no relationship whatsoever with your anabolic steroid manufacturer, distributor and healthcare provider. Initial: _____

ELIV8 MD - Louisville company adhered to by the Department of Regulation Agencies, or DORA, in Colorado, which specifically states that CO medical providers may not prescribe anabolic steroids in the State of Colorado. Initial: _____

Your signature below attests that you understand that you will not ask for, nor receive, anabolic steroids during your patient/provider relationship at ELIV8 MD Louisville. If you desire to use anabolic steroids, you must receive them from a third-party company.

Thank you in advance for your understanding.

Your signature/date: _____

ELIV8 MD

WWW.ELIV8MD.COM

Medical Management Agreement

This agreement between (Print Name)_____and ELIV8 MD- Louisville establishes guidelines and conditions required for the use of hormone replacement therapy (HRT) involving DEA "controlled" or "scheduled" medications. ELIV8 MD and patient agree that these guidelines and conditions are an essential factor in maintaining a successful patient — provider relationship. Adverse side effects and/or physical/psychological dependence may develop after repeated use of these medications and therefore, these agents are prescribed and should be used with caution.

The Patient accepts and agrees to the following conditions:

1. I understand that the medications I have purchased are prescribed for me on a diagnosis derived from medical history I provided, blood/lab work, and a physical examination. They are to be used exclusively for treatment of these diagnoses.

2. I will not attempt to obtain "scheduled" hormone replacement therapy medications legally or from any other health care practitioner without disclosing my current medication usage. I understand that it is against the law to do so.

3. I will immediately report any adverse side effects related to the use of my medication to ELIV8 MD and will discontinue use until advised to resume usage by ELIV8 MD.

4. I understand that the ELIV8 MD providers are available for questions and/or concerns during normal business hours throughout the course of my treatment.

5. I will safeguard my medications from loss of theft and will be responsible for their safekeeping.

6. I agree that these medications are for my personal use only and no other purpose and I will not share, sell, or trade my medications.

7. I agree that I will use these medications at the prescribed rate and dosage and will keep the medication in its respective labeled container.

8. I agree and understand that federal regulations prohibit the return of prescribed medications.

9. I agree that the ELIV8 MD patient provider relationship is not intended to replace the existing patient provider relationship with my current primary care physician (PCP) and my ELIV8 MD treatment will be in conjunction with the care provided by my current PCP.

10. I will certify on my oath that I am not a member of any law enforcement agency engaged in any kind of investigation of ELIV8 MD- Louisville. I am not collecting information for any third party or involved in entrapment of any manner whatsoever regarding ELIV8 MD.

Patient Name: _____

Patient Signature: _____

Date: _____

ELIV8 MD

WWW.ELIV8MD.COM

Notice of Health Information Privacy Practice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read carefully.

Eliv8 MD is required to maintain the privacy of your health information and provide you with a notice of its legal duties and privacy practices. We will not disclose your health information except as described in this notice. This notice applies to all of the medical records generated by

Eliv8 MD as well as records we receive from other providers.

Use and Disclosure of protected Health Information in treatment, payments and Healthcare Operations.

Treatment: Eliv8 MD may use and disclose your protected health information in the course of providing or managing your healthcare as well as any related services. For the purpose of treatment, we may coordinate your health care with a third party. For example, we may disclose your protected health information to a Pharmacy to fulfill a prescription for medication, a radiology facility or order an x-ray, or to another physician who is assisting in your healthcare. In addition, we may disclose protected health information to other providers related to the treatment provided by those other providers.

Payment: When needed, ***Eliv8 MD*** will use or disclose your protected health information to obtain payment for it's services. Such uses or disclosures may include disclosures to your health insurer to get approval for recommended procedure or to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. When obtaining payment for your health care, we may also disclose your protected health information to your Insurance company. Finally we may also disclose your protected health information to another provider where that provider is involved in your care and requires the information to obtain payment.

Operations: Eliv8 MD may use or disclose your protected health information when needed for the practice's health care operations for the purpose of management or administration of the practice and for offering quality health care services. Healthcare operations may include: (1) quality evaluations and improvement activities; (2) Employee review activities and training programs; (3) accreditation, certification, licensing, or credentialing activities; (4) reviews and audits such as compliance reviews, medical reviews, legal services , and maintaining compliance programs; and (5) business management and general administrative activities . For instance, we may use, as needed, protected health information of patients to review their treatment course when making quality assessments regarding ophthalmologic care or treatment. In addition, we may disclose your protected health information to another provider or health plan for their health care operations.

Other uses and Disclosures: As part of treatment, payment, and health care operations, **Eliv8 MD** may also use or disclose your protected health information to: (1) remind you of an appointment; (2) inform you of potential treatment alternatives or options; or (3) inform you of health-related benefits or services that may be of interest to you.

Uses and Disclosures to which you may Object

Family/ Friends: Eliv8 MD may disclose your protected health information to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose protected health information about you to an entity assisting in disaster relief efforts so that your family can be notified about your condition, status and location. If you have any objection to the use and disclosure of your protected health information in this manner, please tell us.

Uses and Disclosures that are required or permitted without your authorization.

Research: Under certain circumstances, ***Eliv8 MD*** may use and disclose your protected health information to approve clinical research studies. While most clinical research studies require specific patient consent, there are some instances where retrospective record review with no patient contact may be conducted by such researchers. For example, the research project may involve comparing the health and recovery of patients who received one medication for their medical condition to those who received a different medication for that same condition.

Regulatory Agencies: Eliv8 MD may disclose your protected health information to government and certain private health oversight agencies, e.g; the department of Public health and Environment or the Board of medical examiners, for activities authorized by law, including, but not limited to licensure, certification, audits, investigations and inspections. These activities are necessary to monitor compliance with the requirements of government programs.

Law Enforcement/Litigation: Eliv8 MD may disclose your protected health information for law enforcement purposes as required by law or in response to a court order or other process in Litigation.

Public Health: As required by law, Eliv8 MD may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury or disability. For example, we are required to report the existence of a communicable disease, such as acquired immune deficiency syndrome "AIDS", to the department of public health and Environment to protect the health and wellbeing of the general public.

Workers Compensation: Eliv8 MD may release protected health information about you for workers compensation or similar programs. These programs provide benefits for work related injuries or illness.

Military/Veterans: Eliv8 MD may disclose your protected health information as required by military command authorities, if you are a member of the armed forces.

Organ Procurement Organization: Eliv8 MD To the extent allowed by law, Eliv8 MD may disclose your protected health information to an organ procurement organization and to other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

As Otherwise required or Permitted by law: Eliv8 MD will disclose your protected health information in any situation in which such disclosure is required by law(eg;, Child abuse, domestic abuse) or any other use permitted under HIPPA, its amendments or regulations.

Uses and Disclosures requiring your Authorization:

Other than the circumstances described above, ***Eliv8 MD*** will not disclose your protected health information unless you provide written authorization. An authorization is specifically required in most situations involving uses or disclosures of protected health information for marketing purposes, for the sale of protected health information, or for psychotherapy purposes. You may revoke your authorization in writing at any time except to the extent that we have already taken action in reliance upon the authorization.

Your rights related to you Health Information:

Although all the records concerning your treatment obtained at **Eliv8 MD** are at the property of **Eliv8 MD,** you have the following rights concerning your protected health information.

- **Right to Confidential communications:** You have the right to receive confidential communications of your protected health information by alternative means or at the alternative locations. For example: you may request that we may contact you at work or by mail.
- **Right to inspect and copy:** You generally have the right to inspect and copy your protected health information, except as restricted by your physician or by law. Further, if we maintain your health records on an electronic health records system, you have the right to request an electronic copy of your health records.
- **Right to Amend:** You have the right to request an amendment or correction to your protected health information. If we agree that an amendment or correction is appropriate, We will ensure that the amendment or correction is attached to your medical records.
- **Right to an accounting:** You have the right to obtain a statement of the disclosures that have been made of your protected health information other than by your authorization, other than to you and other than for the purpose of treatment, payment or routine operational purposes.
- **Right to request Restrictions:** You have the right to request restrictions on certain uses and disclosures of your protected health information. If we agree, we will abide by the restrictions. Additionally, If you (or anyone on your behalf besides a health plan) pay for the services at issue in full out of your own pocket, we are required to comply with your request not to disclose your protected health information to a health plan, unless required by law to do so.
- **Right to receive a copy of this notice:** You have the right to receive a paper copy of this notice, upon request, if this notice has been provided to you electronically.
- **Right to revoke authorization:** You have the right to revoke your authorization to use or disclose your protected health information, except to the extent that action has already been taken in reliance on your authorization.
- **Right to notice of breach of security:** You have the right to be notified in the event that a breach of unsecured protected health information occurs.
- **Right to opt out:** You may be contacted for certain fund-raising purposes and you have the right to opt out of receiving such communications.

For more information regarding how to exercise these rights: If you have questions or would like more information regarding any of the rights listed above, please contact the compliance officer at 720-591-9466.

If you believe that your rights have been violated: You may file a complaint with Eliv8 MD or with the U.S Secretary of health and human services. To file a complaint with Eliv8 MD please contact the compliance officer at 720-591-9466, all complaints must be submitted in writing. There will be no retaliation for filing a complaint.

NOTICE EFFECT DATE: This notice is effective for all protected health information, Created 1/11/2023