Haydee Docasar, M.D.

www.haydeedocasarmd.com

DEMOGRAPHIC & INSURANCE INFORMATION

CONFIDENTIAL

☐ ANNUAL UPDATE
☐ INFORMATION CHANGE

PLEASE PRINT

FULL NAME: _____ **DATE OF BIRTH:** _____

AGE: _____ ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ OTHER: _____

SOCIAL SECURITY NUMBER: _____ EMAIL: _____

ADDRESS: _____ APT/SPACE/UNIT #: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (__) _____ CELL: (__) _____ WORK: (__) _____

EMPLOYER: _____

PRIMARY INSURANCE: _____ POLICY #: _____ GROUP #: _____

GUARANTOR INSURANCE INFORMATION: ☐Self ☐ Spouse ☐ Parent

GUARANTOR NAME: _____ DOB: _____ SS#: _____

ADDRESS: _____ APT/SPACE/UNIT #: _____

CITY: _____ STATE: _____ ZIP: _____

EMPLOYER: _____ PHONE: _____

SECONDARY INSURANCE: _____ POLICY #: _____ GROUP #: _____

GUARANTOR INSURANCE INFORMATION: ☐Self ☐ Spouse ☐ Parent

GUARANTOR NAME: _____ DOB: _____ SS#: _____

ADDRESS: _____ APT/SPACE/UNIT #: _____

CITY: _____ STATE: _____ ZIP: _____

EMPLOYER: _____ PHONE: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY: _____

PHONE: _____ RELATIONSHIP TO PATIENT: _____

☐ I agree to be notified via e-mail regarding updates/announcements in the practice.

☐ I do not agree to be updated via e-mail.

*Note: We do not give your email or personal information to any third parties.

6785 W Russell Road Suite 130 Las Vegas, NV 89118
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Reference Laboratory

Which laboratory is contracted with your Insurance company. Please circle below.

We do not check laboratory benefits.

****Please check with your insurance regarding lab processing and lab draw benefits****

QUEST LAB CORP LMC CPL I DON'T KNOW: INITIAL_____

My signature below indicates that the above information is accurate.

Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

Your Confidential Healthcare Information may be released to other healthcare professionals within this practice for the purpose of providing you quality healthcare.

Your Confidential Healthcare Information may be released to your insurance provider to obtain payment for services provided to you.

Your Confidential Healthcare Information can only be disclosed to you. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but **only** if you give us a written authorization.

Your Confidential Healthcare Information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence

Your Confidential Healthcare Information may be released to other healthcare providers in the event you need emergency care.

Your Confidential Healthcare Information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication) .

Your Confidential Healthcare Information may not be released for any other purpose that which is identified in this notice.

Your Confidential Healthcare Information may be released only after receiving written authorization from you. You may revoke your permission to release confidential healthcare information at any time.

You may be contacted by the practice to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.

You may be contacted by the practice for the purposes of raising funds to support the practice's operations.

You have the right to restrict the use of your confidential healthcare information. However, the practice may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.

You have the right to receive confidential communication about your health status.

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You have the right to review and photocopy any/all portions of your confidential healthcare information.

If you request copies of your health information we will charge you $0.60 for each page, a $25.00 administration fee for staff time to fill out forms (ex: FMLA, short term disability) and postage if you want the copies mailed to you.

If you request an alternative format, we will charge a cost-based fee for providing your health information in that format.

If you prefer, we will prepare a summary or an explanation of your health information for a fee. For more information, contact our HIPPA Compliance Officer listed below.
You have the right to make changes to your confidential healthcare information.

You have the right to know who has accessed your confidential healthcare information and for what.

This practice is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information and will provide patients with a list of duties or practices that protect confidential healthcare information.

• You have the right to complain to this practice if you believe that your rights to privacy have been violated. If you feel that you privacy rights have been violated, please mail your complaint to our HIPPAA Compliance Officer: ATTN: HIPPA Compliance Officer

Dr. Docasar
6785 W Russell Road, Suite 130
Las Vegas, NV 89118

• All complaints will be investigated. No personal issue will be raised for filing a complaint with this practice.

• For further information about this Notice of Privacy Practices, please contact the privacy officer.

This practice will abide by the terms of this Notice. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. Before we make a significant change in our Privacy Practices, we will change this Notice. You may request a copy of our Notice at any time.

Patient Signature: _____ **Date:** _____

Print Name: _____

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NEW MALE PATIENT HISTORY

I. Identifying Information

Name: _____ DOB: _____ Date: _____

Reason for visit _____

Age: _____ Marital Status: _____ Occupation: _____

Who referred you? _____

Name of internist or family doctor: _____

Spouse/Partner's name: _____ Occupation: _____

List any other physicians or health care providers you see and Specialty:

_____

II. Medical History ☐ None

Please list any medical problems that you have.

_____

_____

_____

Have you had any hospitalization, injuries, fractures or motor vehicle accidents? ☐ None

_____

_____

Check if you have or have you ever had:

☐ Alcohol abuse	☐ Anesthetic reaction	☐ Bleeding disorder
☐ Asthma	☐ Anemia	☐ Chronic lung condition
☐ Blood clots	☐ Drug and substance abuse	☐ Depression/anxiety
☐ Diabetes	☐ Heart disease	☐ High blood pressure
☐ High cholesterol	☐ Hepatitis/Jaundice	☐ Cancer (Type)
☐ Irritable bowel syndrome	☐ Kidney stones	☐ Hypothyroidism
☐ Seizure disorder	☐ Stroke	☐ Tuberculosis
☐ Stomach ulcers	☐ Mitral valve prolapse	☐ Rheumatic fever
☐ Transfusion reaction	☐ Eating disorder	☐ Lupus/autoimmune disorder

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List all medications that you take with the dose and timing: ☐ None

Drug	Dose	Frequency	Reason for medication

List all non-prescription medications that you take regularly including vitamins, herbs and anti-inflammatory medications. Please list type, dose and timing: ☐ None

Allergies: List all adverse reactions or allergies you have to medications and what happened. ☐ None

III. Surgical History ☐ None

List all surgeries you have had including biopsies.

Date	Operation	Diagnosis

IV. General Health

How much alcohol do you drink/week? ☐ None ☐ Avg. less than 1/day ☐ Avg. 1/day ☐Avg. more ____

Do you smoke? ☐ Yes ☐ No Amount/day _____ How many years_____

If you quit smoking, when did you stop? _____

Have you used marijuana or other drugs in the last 5 years? ☐ Yes ☐ No Type: _____

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PATIENT CONSENT FORM
Male Hormone Replacement Therapy

Please read and review this consent form and ask questions for clarification if needed.
Then, initial each statement indicating understanding and agreement, and sign at the bottom of the form.

Statement of Patient:

_____ I understand that along with the benefits of any medical treatment or therapies, there are both risks and potential complications to treatment, as well as not being treated. Those risks and potential complications have been explained to me. I have not been promised or guaranteed any specific benefit from the administration of these therapies and no warranty or guarantee has been made regarding the results of treatment. I agree to proceed with treatment and to comply with recommended dosage.

_____ I agree to comply with requests for ongoing testing to assure proper monitoring of my treatments that may include laboratory evaluation of all aforementioned hormone levels or other diagnostic testing by the physician, my primary physician or other specialists. I agree to see my primary care physician, gynecologist, or other practitioner for regular monitoring and for preventative measures that may include but are not limited to complete physicals, rectal examinations and/or colonoscopy, EKG, prostate exams, and PSA levels, etc.

_____ I agree to immediately report to my physician any adverse reaction or problem that might be related to my therapy. I understand that along with the benefits of any medical treatment or therapies, there are both risks and potential complications to treatment, as well as to not being treated. Those risks and potential complications have been explained to me and I agree that I have received information regarding those risks, potential complications and benefits, and the nature of male hormone replacement therapy and other hormone treatments and have had all my questions answered. Some medications such as testosterone, HCG and Arimidex may be used in my hormone replacement therapy. Furthermore, I have not been promised or guaranteed any specific benefit from the administration of bio-identical hormone therapy.

_____ I have been informed that insurance companies may not pay for physician evaluation, laboratory testing, and medications. I therefore agree to pay for all services including physician evaluation, laboratory tests and pharmacy charges, with the understanding that I may not be reimbursed by my insurance company.

_____ **I certify this form has been fully explained to me, that I have read it or have had it read to me. I have been given educated on the benefits, risks, and possible adverse reactions associated with male hormone replacement and/or other hormone treatments. I have been given the opportunity to ask any questions about hormone replacement therapy, potential complications, required testing, and costs and have had them answered to my satisfaction. I agree not to undergo any treatments unless I fully understand the treatment and have discussed possible risks and benefits. I fully understand what I am signing and herby request and consent to treatment using male hormone replacement therapy and/or hormone treatments.**

Signature of Patient: _____ Date: _____

Name (PRINT): _____ Date: _____
If patient is a minor,
Parent/ Legal Guardian Signature: _____ Date: _____

Name (PRINT): _____ Relationship: _____

Statement of Prescriber:
I have explained the therapy, its intended benefits and risks, and possible reactions to the patient. I have confirmed that the patient understands the risks and benefits, has no further questions and gives consent to initiate male hormone replacement therapy.

Signature of Prescriber: H Docasar MD Date: _____

Name (PRINT): Haydee Docasar MD.