(425) 806-4600 • nh-hormones.com

Patient Registration

Name:_____ Birthdate:____/____/_____
(LAST) (FIRST) (MI)

Home Address:_____City:_____ State:____ Zip:_____

Preferred Phone #: (_____)_____ EMAIL:_____

Emergency Contact Person:

Name: _____ Phone # (____)_____ Relationship: _____

Who is your current Primary Care Provider?

_____

Provider Name / **Clinic & Location** / **Phone & Fax #**

As a courtesy, we can send your health insurance information with any lab orders so that the laboratory can attempt to bill your insurance for lab tests deemed necessary by the Provider. Please remember it is your responsibility to contact the lab if needing to update or correct any insurance or contact information, and submission of insurance information is not a guarantee of coverage or payment. As stated on our Fee Schedule, we do not accept insurance for services provided by New Horizon Hormones.

Insurance Company:_____ Plan Name: _____

Subscriber Name:_____ Subscriber's DOB:____/____/_____
(LAST) (FIRST) (MI)

Relationship to Patient: _____

Subscriber/Member ID Number (Include all letters and numbers): _____

Group Number: _____

Address to send medical claims (on back of card): _____

OR ☐ Submit claims to local BlueCross BlueShield Plan?

Printed Name: _____

Patient Signature: _____ Date: _____

Please return all completed forms via secure fax: (855) 615-2852 / (425) 806-4622 or email to: nhhormones@protonmail.com. If you would prefer to mail your forms back to us via USPS, send to: P.O. Box 1732, Snohomish, WA 98291-1732

08/2021

Fee Schedule & Patient Responsibility Acknowledgement

Pricing is based on time spent and complexity of each individual appointment. Payment is required in full at the time of service. We accept VISA, Mastercard, American Express, and Discover Cards. We do not accept insurance.

*Most Visits will be **virtual** via a HIPAA secure tele-health platform. Instructions will be given upon scheduling.*

Initial Consultation (60-75 minutes)	$250
Follow Up and Additional Appointments, as needed (30-60 minutes)	$125 - $200
Annual Maintenance Appointment (30 minutes)	$125 (Prescription refills for 1 year)

Patient Responsibility Acknowledgement (PLEASE READ CAREFULLY):

By signing this form, I understand and agree that I am financially responsible for all charges for any and all services rendered, due at the time of service. I may request a copy of my receipt of payment to submit to my insurance company for consideration of reimbursement. I understand that payment or reimbursement from my insurance company is not guaranteed and is dependent upon the policy benefits of my particular insurance plan. I understand I will be responsible for any laboratory tests and/or fees as deemed necessary and ordered by the Provider. If wanting to utilize insurance benefits for laboratory tests, I understand it is my responsibility to make sure the laboratory has my updated insurance and contact information on file. I understand that I am responsible for keeping track of my medication refills and request for additional refills must be given at least 1 week before the medication runs out to allow time for my provider and my pharmacy to fulfill this request.

If you are unable to keep your scheduled appointment, we ask that you give adequate notice (24 hours, or prior to appointment time on the same day in an emergency situation) so that we may open your reserved time for another patient. If you miss an appointment without adequate notice, you will be required to pay a $50 deposit prior to scheduling further appointments. This is a good-faith deposit to reserve your appointment time. When the appointment is kept, this $50 fee will be applied to your office visit fees or refunded as appropriate. If the appointment is missed without proper notice of cancellation, the deposit becomes non-refundable and we may dismiss you as a patient for future visits.

Print Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Health Inventory

Name: _____ Age:_____ DOB:_____

Preferred Pharmacy: _____ Location & Phone #:_____

Were you recommended by a particular **Compounding** Pharmacy? **YES / NO**

If YES, name of Compounding Pharmacy who referred you: _____

Date of last appointment with your PCP: _____ Have you had labs done in the last 2 years? Y / N

If you do have recent lab results, please send a copy of results with your initial paperwork or request that your provider fax them to us at: 855-615-2852 prior to your scheduled appointment.

Current Medications and Dosages (Please attach additional page if needed):

Supplements/Vitamins:

ALLERGIES (to medications or severe food allergy):

_____

Significant Medical History (list any major medical problems and/or diagnoses with dates if possible)

_____

_____

_____

Obstetric History:

Are you planning a pregnancy in the near future? YES / NO

# of Pregnancies: _____ # of Births: _____ # of Miscarriages _____

Any significant complications w/ pregnancy or delivery? _____

Gynecologic History:

Are you sexually active? YES / NO Any pain with intercourse? YES / NO

Specifics of sexual concerns you are wanting to discuss if any?

_____

Current birth control method: _____ How long? _____

Are you currently having periods? YES / NO

If YES:

Date of last period? _____

Are they regular? YES / NO Average # Days of flow: _____ Length of cycle: _____

Amount of flow: Heavy Moderate Light Severity of Cramps: Light Moderate Severe

Premenstrual Symptoms: _____

Any bleeding between periods? YES / NO When? _____

Do you have concerns about your periods? _____

If NO:

Age of Menopause_____ Natural / Surgical

Hysterectomy: Date & Reason: _____ Ovaries intact? YES / NO

Are you currently taking hormones? Type & Dose? _____

What Hormonal symptoms are most bothersome? _____

_____

Pap Smears: Date of last Pap: _____ History of Abnormals?: _____

Breasts: Date of last Mammogram: _____ Any Significant History? _____

Colonoscopy or Colon Cancer screening? YES/NO Date & Results: _____

Previous DEXA (Bone Density) scan? YES / NO

Date & Results: _____ Normal / Osteopenia / Osteoporosis

Thyroid History: Please describe any concerns you have about thyroid function: _____

_____

Habits:

Nicotine Usage (Circle one): Current Former Never

Dietary Restrictions: _____

Routine Exercise: _____ How often? _____

Current Stresses (family, work, self, etc): _____

Personal Health Goals ?_____

Family and Personal History:

	ME	Family: Who?		ME	Family: Who?
Breast Cancer	☐	_____	Skin Cancer	☐	_____
Ovarian Cancer	☐	_____	Alcoholism	☐	_____
Colon Cancer	☐	_____	Thyroid disorder	☐	_____
Hypertension	☐	_____	Osteoporosis	☐	_____
Blood Clots	☐	_____	Depression	☐	_____
Heart Disease	☐	_____	Anxiety	☐	_____
High Cholesterol	☐	_____	Early Menopause	☐	_____
Metabolic Syndrome/PCOS	☐	_____	Kidney Disease	☐	_____

Autoimmune Disorders (RA, Lupus, MS, etc.) _____

Review of Systems: (Circle any symptom of **current** concern.)

General: Fatigue Temperature Instability Bone & Joint pain Weight Change Foggy Brain

Abdomen: Bloating / Cramping Heartburn Nausea/vomiting Diarrhea / Constipation

Head: Headaches Dizziness Visual Changes Hearing Changes Sinus trouble

Chest: Chest pain Shortness of breath Palpitations Asthma/Wheezing Cough

Breasts: Lumps Tenderness Nipple Discharge Fibrocystic or dense breasts

Bladder: Frequent urination Painful urination Leakage of urine Recurrent bladder infections

Psychiatric: Depression Anxiety Mood Instability Irritability

Skin & Hair: Overly Dry Hair Thinning Unusual Hair growth Skin eruptions

Additional Concerns:_____

Hormone Assessment Questionnaire

Name: _____ Date: _____ Age: _____

Last Menstrual Period? _____ NATURAL MENOPAUSE? _____ HYSTERECTOMY? _____OVARIES Y N

PLACE AN X ON ANY THAT CURRENTLY APPLY TO YOU:

- [ ] Have you noticed recent weight gain, especially around your middle?
- [ ] Have you had increased fatigue lately?
- [ ] Do you experience a mid-day energy slump?
- [ ] Does your hair and skin seem especially dry?
- [ ] Is your digestion sluggish and/or do you get constipated a lot?
- [ ] Have you noticed an increase in "brain fog" or problems with cognitive focus?
- [ ] Are you having changes from your regular sleep cycle?
- [ ] Do you suffer from hot flashes?
- [ ] Do you experience night sweats?
- [ ] Are you more forgetful than you used to be?
- [ ] Do you feel depressed, or simply "flat" and uninspired?
- [ ] Have you lost your sense of vitality, are you less assertive?
- [ ] Is your skin more dry and less elastic or plump - or are you noticing other signs of aging?
- [ ] Does your skin ever tingle or itch?
- [ ] Do most things seem like a chore to you lately?
- [ ] Has your sexual drive diminished significantly or has your sexual response lessened or changed?
- [ ] Do you notice less vaginal lubrication than before?
- [ ] Do you sometimes experience anxiety or panic?
- [ ] Are you experiencing adult onset acne?
- [ ] Do you have body or joint pain?
- [ ] Have you recently lost muscle mass?
- [ ] Have you noticed your hair thinning?
- [ ] Does you face feel more oily than usual?
- [ ] Have you noticed an increase in dark hair growth on your chin or upper lip?

IF YOU ARE STILL HAVING PERIODS PLEASE ANSWER THE FOLLOWING:

- [ ] Are your periods irregular?
- [ ] Do you spot before your periods?
- [ ] Are your menstrual cramps worse than in years passed?
- [ ] Have your periods gotten heavier?
- [ ] Do you experience premenstrual breast pain? Breast size increase?
- [ ] Do you experience premenstrual water retention?
- [ ] Have you been diagnosed with having fibroids?
- [ ] Are you more nervous premenstrually?
- [ ] Do you experience poor quality sleep before and during your period?

NEW HORIZON HORMONES
LAUREN SCHWEIZER, ARNP

P.O. Box 1732
Snohomish, WA 98291-1732
Phone: (425) 806-4600 Fax: (855) 615-2852

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize New Horizon Hormones/Lauren Schweizer, ARNP to disclose and/or receive **PHI** for:

Patient Name: _____ DOB: _____

Previous Name Used: _____ Phone # _____

To/From the following Facility/Provider: **(Please fill in contact information for your Primary Care Provider)**

Name of Facility/Provider	
Address, City, State	
Phone #	Fax #

(OPTIONAL - PLEASE READ CAREFULLY) Specific information to be **EXCLUDED** from this authorization: This release **MAY NOT** include specific information related to:

PLEASE INITIAL NEXT TO DESIRED EXCULSIONS IF APPLICABLE:

Testing, diagnosis, and/or treatment for HIV/AIDS _____
Sexually transmitted diseases _____
Psychiatric disorders/mental health _____
Drug and/or alcohol use / Substance Abuse _____

(For office use only) Type of information to be requested and/or received:

___ Lab Results
___ Pap Smear Results
___ Preventative Chart Note
___ Visit/Progress Notes: _____
___ DEXA Report
___ Mammogram Report
___ Other: _____

I understand I may revoke this consent at any time except to the extent that action has been taken in reliance upon it. If not revoked, this authorization expires 1 year from the date of signature unless otherwise specified. (RCW 70.02.030) I understand I have the right to receive a copy of this authorization form.

X_____ X_____

Signature of Patient **Today's Date**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Do you give NHH permission to leave a voicemail regarding appointment reminders and/or lab results?

YES: ☐ Preferred Phone Number: (_____)_____

NO: ☐ Please **DO NOT** leave messages

Do you give NHH permission to send emails and/or text messages to you regarding appointment reminders, and clinic information, updates, and/or clinic promotions?

YES: ☐

NO: ☐ Please **DO NOT** email or text this information

Many of our patients allow family members or others close to them to call and request information regarding their condition and/or treatment. Under the requirements for HIPAA we are not allowed to give this information to anyone without the patient's written consent. Because of this, we must have permission from you to share any medical related information. If you would like to give us permission to share any of your Personal Health Information (PHI) please list their name(s) below:

Name:_____ Phone #:_____ Relationship to Patient:_____

Name:_____ Phone #:_____ Relationship to Patient:_____

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment, and health care operations, and/or as required by law. I have the right to revoke any or all portions of this consent at any time, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior consent. NHH provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). By signing this form, I acknowledge that New Horizon Hormones has provided me with a copy of Notice of Privacy Practices which describes in more detail how your Personal Health Information may be used and disclosed, and how you may access your information.

Printed Name: _____ **Date of Birth:** ____/____/_____

Patient Signature :_____ **Today's Date:** _____

Notice of Privacy Practices (NPP)

New Horizon Hormones

Lauren Schweizer, ARNP

This Notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please Review it carefully.

I. UNDERSTANDING YOUR HEALTH INFORMATION

Each time you visit our clinic, a record of your visit is created. This record usually contains your name and other information that may identify you, your symptoms, examination and test results, diagnoses, treatment plan for future health care, and financial information. This record is sometimes referred to as your "medical chart" or "medical record".

This record allows:

- Doctors, nurses, and other health professionals to plan your treatment;
- Our clinic to obtain payment for services we provide to you, such as from insurance, or you; and
- Our clinic to measure the quality of care provided to you.

We are committed to keeping your health information confidential. We will not use or give to others your health information without your written permission, except as otherwise stated in this notice.

II. HOW WE WILL USE AND GIVE OUT YOUR HEALTH INFORMATION

a. Treatment, Payment, and Health Care Operations

We will use and give out your health information to provide you with health care treatments, to get paid for our services, and to help us operate our clinic. **For example:**

- We will give your health information to health care professionals not on our staff, such as doctors and/or hospital staff who are helping to care for you such as your Primary Care Provider;
- We may send a bill to your health insurance plan, or to you; and
- Our clinic may use your medical records to review our performance and make sure you receive quality health care.

b. Other Uses and Disclosures Allowed or Required by Law

We may use or give out your health information for the following purposes under limited circumstances:

- To people who are involved in your care or who help pay for your care, such as your family, your close personal friends, or any other person chosen by you, to notify them of your location, general health, and to assist you in your healthcare (such as to pick up medicine or help with follow-up care);
- To government agencies that oversee our clinic (such as license and certification inspectors);
- To government agencies that have the right to receive and collect health information (such as to control disease outbreaks);
- When ordered by a court or judge;
- To workers' compensation programs when your health problem is from a work-related injury;

- When law enforcement requests information (such as to prevent danger or injury);
- To coroners and funeral directors to allow them to carry out their duties;
- To organ donor agencies (subject to applicable laws);
- To avoid a serious threat to the health or safety to yourself or others;
- To contact you about new treatments or medicines that may help you;
- To business associates of the clinic that help us perform required tasks, such as our accountants, computer consultants, and billing companies (only if the business associate agrees in writing to keep your health information confidential as required by law); and
- For any other purpose required or allowed by law.

c. Other Uses and Disclosures Requiring Your Written Permission:

Except as stated above, we will use or give out your health information only after getting your written permission on an authorization form. You may revoke your authorization at any time by notifying us in writing that you wish to do so.

III. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Subject to certain legal limits, you have rights regarding the use and disclosure of your health information, including the rights to:

- Request limits on uses of your health information
- Receive confidential communications of your health information
- Inspect and copy your health information
- Request a change to your health information
- Receive a record of how we have used and given out your health information
- Obtain a copy of this Notice of Privacy Practices

IV. QUESTIONS, CONCERNS, AND CHANGES TO THIS NOTICE:

If you have any questions or want to talk about any of the information in this Notice of Privacy Practices, please contact the Practice Manager at New Horizon Hormones
Phone: 425-806-4600

If you believe your privacy rights have been violated, you may file a complaint with our clinic or with the Secretary of the Department of Health and Human Services. To file a complaint with our clinic, submit it to the Practice Manager at: P.O. Box 1732, Snohomish, WA 98291-1732. All complaints must be submitted in writing.
We will not retaliate against you for filing a complaint.

We may change our Notice of Privacy Practices in the future, such changes will apply to your health information that we created or received before the effective date of the change. We will notify you of any changes to our Notice of Privacy Practices by posting the changed notice at our clinic and on our website.