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Client Information

Name:	Today's Date:
Phone Number(s): Cell: Home:	Date of Birth:
Email Address:	Primary Care Doctor:
Referred by:	Social Security Number:
Street Address:	Health Insurance Information Company: Policy (ID) Number:
What are your main reasons for seeking care today? (List most important condition first)	
Occupation:	
Allergies (food and/or drug):	
List ALL prescription medications you are currently taking:	
List ALL vitamin, nutritional or natural products you are currently taking:	

Female Hormone Questionnaire

Have you had any of the following surgeries:	
Hysterectomy? Yes or No	Date of Surgery: Reason for Surgery:
Ovaries Removed? Yes or No Date of your last Pap Smear: Normal or Abnormal (circle one)	Date of your last Mammogram: Normal or Abnormal (circle one) Findings if Abnormal:

Circle any of the following conditions you have had previously or currently and estimated date of diagnoses:			
Thyroid disease		Heart disease	
Fibrocystic breast disease		Headaches/Migraines	
Endometriosis		Lupus/Fibromyalgia /Autoimmune disease	
Blood Clotting Disorder		Osteoporosis	
High blood pressure		Cancer	
High Cholesterol		Other:	
Is there a family history of:			
Uterine Cancer?	Yes or No	Breast Cancer?	Yes or No
Ovarian Cancer?	Yes or No	Osteoporosis?	Yes or No
Heart Disease?	Yes or No		

Do you still have your period? Yes or No
If not, age at menopause or hysterectomy: ________
Do you have regular menses? Yes or No If yes, date of your 1st day of last period:__________
Do you or did you have PMS or PMDD? Yes or No
Do you or did you have cramps? Yes or No
Have you ever taken birth control pills? Yes or No
Are you currently taking birth control pills? Yes or No If yes, which one?
Do you currently smoke cigarettes? Yes or No

Rate the following if you have experienced any of these symptoms recently? 0 Lowest – 5 Highest						
Sleep disruption/Insomnia	0	1	2	3	4	5
Decreased libido (sex drive)	0	1	2	3	4	5
Night sweats	0	1	2	3	4	5
Depression	0	1	2	3	4	5
Fatigue	0	1	2	3	4	5
Fluid retention	0	1	2	3	4	5
Vaginal dryness/Painful Intercourse	0	1	2	3	4	5
Migraines/headaches	0	1	2	3	4	5
Irritability	0	1	2	3	4	5
New facial hair	0	1	2	3	4	5
Nervousness/Anxiety	0	1	2	3	4	5
Decreased quality of orgasm or intercourse	0	1	2	3	4	5
Hot flashes	0	1	2	3	4	5
Breast tenderness	0	1	2	3	4	5
Dry skin	0	1	2	3	4	5
Mood swings	0	1	2	3	4	5
Crying easily	0	1	2	3	4	5
Weight gain	0	1	2	3	4	5
Short term memory loss	0	1	2	3	4	5

Frequent Urination	0 1 2 3 4 5
Poor concentration	0 1 2 3 4 5
Food cravings	0 1 2 3 4 5
Backaches	0 1 2 3 4 5
Hair loss	0 1 2 3 4 5
Increased Nipple Sensitivity	0 1 2 3 4 5

Do you have any questions, comments, or concerns regarding Hormone Replacement Therapy (HRT)?

Waiver of Liability:

Being fully informed about your condition and treatment will help you make the decision whether or not to undergo hormone replacement therapy treatment. This disclosure is not meant to alarm you; it is simply an effort to better inform you so that you may give or withhold your consent for this treatment.

I understand that hormone replacement therapy is not an exact science and each and every individual is unique, therefore a treatment that works for one person may not necessarily work for myself. Dr. Willson understands this theory and will work diligently to customize your treatment both subjectively and objectively. Your feedback is instrumental in the success of treatment.

I agree that this constitutes full disclosure and that it supersedes any previous verbal or written disclosures. I certify that I have read and fully understand the above paragraph and that I have had sufficient opportunity for discussion and to ask questions. I consent to this hormone replacement therapy treatment today and for all subsequent treatments.

Patient's Signature: ______________________________ **Date:**______________

Hormone Replacement Therapy Treatment Rates: Initial Consultation, Lab Evaluation and all follow up visits - $395 due annually on July 1st. Typical follow up sessions are every 4-6 months for 30 minutes. This fee does not include lab work or medications, labs are required to continue treatment and are typically drawn every 6 months but no less than annually.

2014 Hormone Replacement Therapy, Prescription & Procedure Fee Schedule*

(Please Select ONE of the Following Options)

Name: ____ **Due July 1st, 2014**

□ Purity Basic: $395 Annually
- ~Initial Consultation and Follow Up Appointments.
- ~Ordering and Evaluation of Labs
- ~Written Prescriptions*
  - •This includes all HRT, Thyroid, Phentermine, Adderall and Accutane Patients

□ Purity Premium: ~Testosterone injections – Every 2 Weeks (26 Injections)
- ~All of the above in the Purity Basic Plan
- □ $1600 Annually (Savings of $485) or □ $65 Per Injection + $395 Annually

□ Purity Platinum: ~Sub-dermal Pellet Implantation
- ~All of the above in the Purity Basic Plan
- □ Men - $1625 annually (3 treatments – Savings of $495) or □ $575 Per Treatment + $395 Annually
- □ Women - $1400 annually (4 treatments – Savings of $495) or □ $375 Per Treatment + $395 Annually

□ Purity Individual Office Visit: ~For Monthly Prescriptions such as Phentermine, Adderall & Accutane Only – In lieu of paying the annual fee and $95 is due at the conclusion of each visit.

□ I no longer wish to use Purity Wellness Center for my Hormone Replacement Therapy or monthly prescription requirements, please refer me to another physician to continue these services.

Add-Ons:
- □ Labs (Includes 2 Lab Visits to Quest Diagnostics Annually) $825
  All laboratory draws will be billed to and covered by Purity Wellness Center – Designed for patients without health insurance or high deductible insurance.
- □ Vitamin B12 injections
  Single $25 □ 26 Injections $450 (Save $200) □ 52 Injections $850 (Save $450)

*All prescriptions will be dispensed annually as long as current laboratory results and current patient information is on file.

Please return this invoice with your payment by July 1st, 2014. If payment is not received by July 1st a 10% late fee will be assessed and a disruption in prescriptions may occur. If you have any questions regarding this fee schedule you may call our office at 913-653-3614. Completed forms with credit card information may be securely faxed to 913.839.1437 or emailed to puritywellnesscenter@gmail.com, a receipt will be emailed upon processing.

In Good Health,
Dr. Scott and the PWC Team

Please mark method of payment:

Visa – MasterCard – American Express – Discover Total Amount Authorized $__________ Check #_______

Name of Cardholder: ____

Billing Address of Cardholder: ____

Credit Card Number: ____________________________________

Expiration Date: _______________ CV Code: _________

Cardholder Signature: ______________________________ Date: ______________