RIVERSIDE MEDICAL ARTS

Received and completed by _____

PATIENT INFORMATION

Title	Sex	Date of Birth
☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Jr ☐ Sr ☐ II ☐ I	☐ Female ☐ Male	mm / dd / yyyy

First Name	Middle Initial	Last Name	Social Security Number
			- -

Physical Address	City	State	Zip

Mailing Address	City	State	Zip

Preferred Phone Number	Home Phone Number	Cell Phone Number	Work Phone Number
( ) -	( ) -	( ) -	( ) -

Email Address	Confidential Communication Preference
	☐ Email ☐ Letter ☐ Other _____ ☐ Patient Portal

Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed

Preferred Language	Ethnicity
	☐ Hispanic or Latino ☐ NOT Hispanic or Latino ☐ Unknown

Race
☐ American Indian ☐ Asian ☐ Black /African American ☐ Native Hawaiian ☐ Other Pacifica Islander ☐ White ☐ Other

Employer Name

Preferred Provider
☐ Gayle M Carter, MD ☐ Allie Blazzard, FNP - C

PARENT / LEGAL GUARDIAN / LEGAL REPRESENTATIVE INFORMATION

Title	Sex	Date of Birth
☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Jr ☐ Sr ☐ II ☐ I	☐ Female ☐ Male	mm / dd / yyyy

First Name	Middle Initial	Last Name	Social Security Number
			- -

Address	City	State	Zip	Email Address

Relation to Patient	Home Phone Number	Cell Phone Number	Work Phone Number
	( ) -	( ) -	( ) -

PRIMARY INSURANCE

Insurance Carrier Name		
Group Name	Group Number	
Subscriber Name		
Subscriber ID		
Subscriber Date of Birth	Relation to Patient	

Employment Status
☐ Employed ☐ Unemployed ☐ Retired ☐ Student

SECONDARY INSURANCE

Insurance Carrier Name	
Group Name	Group Number
Subscriber Name	
Subscriber ID	
Subscriber Date of Birth	Relation to Patient

Employment Status
☐ Employed ☐ Unemployed ☐ Retired ☐ Student

SPOUSE OR EMERGENCY CONTACT

First Name	Last Name	Relation to Patient

Home Phone Number	Cell Phone Number

REFERRAL

How did you hear about our clinic?

Referred by

SIGNATURE

Signature of Patient or Legal Guardian	Date
	mm / dd / yyyy

Patient Account # _____

RIVERSIDE MEDICAL ARTS

PATIENT HEALTH INFORMATION

First Name	Middle Initial	Last Name	Date of Birth mm / dd / yyyy

Preferred Pharmacy	Pharmacy Location
Primary Care Physician	**Primary Care Physician Phone Number**

How would you describe your overall health	Smoking/ Tobacco History	Alcohol Use	Drug Use	Caffeine use
☐ Excellent ☐ Good ☐ Fair	☐ Never ☐ Previous ☐ Current	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

ALLERGIES AND REACTIONS

Allergy	Describe Reaction	Allergy	Describe Reaction
Allergy	Describe Reaction	Allergy	Describe Reaction

CURRENT MEDICATIONS/HORMONES/SUPPLEMENTS/VITAMINS

Name	Dose / Strength	Frequency	Date Started

MALE HEALTH HISTORY

Date of last rectal exam	Date of last prostate exam	Date of last PSA blood test

Do you have, or have you ever had prostate cancer?
☐ Yes ☐ No If YES, Please explain:

PREVIOUS HOSPITALIZATIONS OR SURGICAL PROCEDURES

Date / /	Date / /	Date / /	Date / /
Date / /	Date / /	Date / /	Date / /

FAMILY MEDICAL/CANCER HISTORY

Relation to patient ☐ Anemia	Relation to patient ☐ Fibrocystic Breast	Relation to patient ☐ Breast Cancer
Relation to patient ☐ Bleeding Disorder	Relation to patient ☐ Heart Disease	Relation to patient ☐ Ovarian Cancer
Relation to patient ☐ Diabetes	Relation to patient ☐ Hypertension	Relation to patient ☐ Prostate Cancer
Relation to patient ☐ Endocrine Problem	Relation to patient ☐ Osteoporosis	Relation to patient ☐ Other:

Patient Account # _____

RIVERSIDE MEDICAL ARTS

First Name	Middle Initial	Last Name	Date of Birth mm / dd / yyyy

MEDICAL HISTORY DETAIL

(Please check all applicable symptoms that you have or have had)

- ☐ Abdominal pain
- ☐ Acne
- ☐ Altered sense of smell
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Ataxia
- ☐ Black stools
- ☐ Bladder infections
- ☐ Bleeding tendency
- ☐ Blood clots
- ☐ Blood in mucus
- ☐ Blood in stool
- ☐ Blood in urine
- ☐ Blood transfusions
- ☐ Blurry vision
- ☐ Bowel problem
- ☐ Cancer
- ☐ Change in hair growth
- ☐ Change in skin color
- ☐ Chest pain – exerted
- ☐ Chest pain – resting
- ☐ Chills
- ☐ Cold hands or feet
- ☐ Constipation
- ☐ Coordination problems
- ☐ Coughing up of blood
- ☐ Depression
- ☐ Dermatitis
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Dizziness
- ☐ Double vision
- ☐ Dry eyes
- ☐ Dry mouth
- ☐ Dry skin
- ☐ Dysphagia (difficulty swallowing)
- ☐ Ear pain
- ☐ Enlarged prostate
- ☐ Epilepsy
- ☐ Excessive hunger
- ☐ Excessive thurst
- ☐ Exercise intolerance
- ☐ Extremity weakness
- ☐ Eye disease (Glaucoma, etc)
- ☐ Eye pain
- ☐ Fatigue
- ☐ Fecal incontinence
- ☐ Fever
- ☐ Food allergies
- ☐ Fractures
- ☐ Gait disturbance
- ☐ Genital discharge
- ☐ Genital infections
- ☐ Goiters
- ☐ Hay fever
- ☐ Headaches / Migraines
- ☐ Hearing loss
- ☐ Heartburn
- ☐ Heart disease/Heart failure
- ☐ Heart problems
- ☐ Heavy bleeding
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ High cholesterol or lipids
- ☐ Hives
- ☐ Insomnia
- ☐ Intolerance to heat or cold
- ☐ Irregular periods
- ☐ Joint instability
- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Joint swelling
- ☐ Kidney disease
- ☐ Kidney problems
- ☐ Liver disease
- ☐ Lung problems
- ☐ Lupus
- ☐ Lymph node enlargement
- ☐ Medication allergies
- ☐ Mouth pain
- ☐ Muscle pain (myalgias)
- ☐ Muscle weakness
- ☐ Nasal congestion
- ☐ Neck pain
- ☐ Night sweats
- ☐ Nervousness
- ☐ Numbness
- ☐ Ovarian problems
- ☐ Pain in feet or hands
- ☐ Pain with inhalation
- ☐ Pain with intercourse
- ☐ Palpitations
- ☐ Paresthesias (tingling/pricking)
- ☐ Post nasal drip
- ☐ Productive cough
- ☐ Rapid heart rate
- ☐ Rash
- ☐ Rectal bleeding
- ☐ Seasonal allergies
- ☐ Seizures
- ☐ Sever itching (pruitis)
- ☐ Shortness of breath
- ☐ Skin cancer
- ☐ Skin disease
- ☐ Skin lesions
- ☐ Skin nodules
- ☐ Skin ulcers
- ☐ Sore throat
- ☐ Speech disturbance
- ☐ Sprain
- ☐ Stomach problems
- ☐ Suicidal
- ☐ Syncope (fainting)
- ☐ Thyroid disease/ problems
- ☐ Tingling
- ☐ Tinnitus (ringing in ears)
- ☐ Trouble swallowing
- ☐ Ulcers
- ☐ Urinary incontinence
- ☐ Urinary frequency
- ☐ Venereal disease
- ☐ Visual acuity
- ☐ Visual changes
- ☐ Weight gain
- ☐ Weight loss
- ☐ Wheezing
- ☐ Yeast infections

Patient Account # _____

RIVERSIDE MEDICAL ARTS

HORMONE REPLACEMENT THERAPY

First Name	Middle Initial	Last Name	Date of Birth
			mm / dd / yyyy

How did you arrive at the decision to consider Bio-Identical Hormone Replacement Therapy?

☐ Doctor ☐ Self ☐ Friend / Family member ☐ Other:

What are your goals with taking Bio-Identical Hormone Replacement Therapy?

Please write down any questions that you have about Bio-Identical Hormone Replacement Therapy:

CURRENT SYMPTOMS	RATE SEVERITY OF EACH SYMPTOM			
ACNE	☐ Absent	☐ Mild	☐ Moderate	☐Severe
ANXIETY	☐ Absent	☐ Mild	☐ Moderate	☐Severe
ARTHRITIS	☐ Absent	☐ Mild	☐ Moderate	☐Severe
BLADDER SYMPTOMS	☐ Absent	☐ Mild	☐ Moderate	☐Severe
DECREASED SEX DRIVE	☐ Absent	☐ Mild	☐ Moderate	☐Severe
DEPRESSION	☐ Absent	☐ Mild	☐ Moderate	☐Severe
DRY SKIN/HAIR	☐ Absent	☐ Mild	☐ Moderate	☐Severe
DRY THINNING SKIN	☐ Absent	☐ Mild	☐ Moderate	☐Severe
FATIGUE/LACK OF ENERGY	☐ Absent	☐ Mild	☐ Moderate	☐Severe
HAIR LOSS	☐ Absent	☐ Mild	☐ Moderate	☐Severe
HARDER TO REACH CLIMAX	☐ Absent	☐ Mild	☐ Moderate	☐Severe
HEADACHES	☐ Absent	☐ Mild	☐ Moderate	☐Severe
HOT FLASHES	☐ Absent	☐ Mild	☐ Moderate	☐Severe
IRRITABILITY	☐ Absent	☐ Mild	☐ Moderate	☐Severe
LOSS OF MEMORY	☐ Absent	☐ Mild	☐ Moderate	☐Severe
MOOD SWINGS	☐ Absent	☐ Mild	☐ Moderate	☐Severe
MUSCLE WEAKNESS / LOSS OF STRENGTH	☐ Absent	☐ Mild	☐ Moderate	☐Severe
NIGHT SWEATS	☐ Absent	☐ Mild	☐ Moderate	☐Severe
SENSITIVITY TO COLD	☐ Absent	☐ Mild	☐ Moderate	☐Severe
SLEEP DISTURBANCES / INSOMNIA	☐ Absent	☐ Mild	☐ Moderate	☐Severe
TROUBLE WITH EJACULATION	☐ Absent	☐ Mild	☐ Moderate	☐Severe
TROUBLE WITH ERECTION	☐ Absent	☐ Mild	☐ Moderate	☐Severe
THINNING BONES	☐ Absent	☐ Mild	☐ Moderate	☐Severe
WEIGHT GAIN AROUND MID SECTION	☐ Absent	☐ Mild	☐ Moderate	☐Severe

ADDITIONAL SYMPTOMS

Please list any additional symptoms you may be experiencing:

Patient Account # _____

RIVERSIDE MEDICAL ARTS

Patient First Name	Patient Last name
Parent / Guardian Name	Relation to Patient

NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been offered / provided with a copy of Riverside Medical Arts Notice of Privacy Practices.

PATIENT RIGHTS AND RESPONSIBILITIES

My signature below indicates that I have been offered / provided with a copy of Riverside Medical Arts patient rights and responsibilities.

DISCLOSURE OF OWNERSHIP INTEREST

My signature below indicates that I have been offered / provided with a copy of Riverside Medical Arts disclosure of ownership interest.

LABORATORY

My signature below indicates I understand that all lab work ordered by my physician and sent to an outside lab will be billed separately by that lab to my insurance company. I understand that I am responsible to pay for all lab charges, whether or not I have insurance and whether or not it is a covered benefit of my insurance. I understand that the laboratory will bill me separately for these lab charges.

FINANCIAL RESPONSIBILITY / ASSIGNMENT OF BENEFITS / BILLING AGREEMENT

Insurance is a way for you to receive repayment for fees you have paid to a physician for services rendered. Having insurance is not a substitute for payment. Even though insurance companies have a fixed allowance or percentage based on your policy with them, your policy is with your insurance company, not with this office. It is your responsibility to provide payment for the deductible, co-insurance, and any other balances not paid for by your insurance. We will assist you in receiving reimbursement in any way possible, but you are ultimately responsible for the payment of your bill. Please provide complete insurance information to our office prior to your visit. If this information is not produced, payment for the services rendered will be due at the time of your visit. It is your responsibility to know the benefits provided by your insurance carrier. Please direct questions regarding your benefits to your insurance carrier or your human resources department. Riverside Medical Arts will make a reasonable attempt to inform you if your insurance is out of network. However, if your insurance is out of network you are responsible to pay for all services rendered. Payment in full will be due at the time of service if a particular service is not covered, we are unable to verify coverage, your coverage is pending or you are ineligible for coverage. Our office will file a claim with your primary insurance carrier. If a service requires additional information from the patient / guarantor, you are required to provide the necessary information to your insurance company or our office as soon as possible. If this information is not received by either the insurance company, or our office the payment for services rendered will then be the responsibility of the patient / guarantor. As a courtesy our office will file a claim with your secondary insurance company. If the services are unpaid by your secondary insurance carrier or require follow up, payment for services rendered are the responsibility of the patient / guarantor. In the event that your insurance company refuses payment for services rendered, you will be responsible for payment in full. A denial from your insurance company does not release you from your financial obligation to us. Payments on accounts billed are expected within 30 days of the statement date. A $25.00 returned check fee will apply for every returned check that is received by our office. Delinquent accounts will be charged interest at 1.5% per month. The undersigned specifically agrees to pay all reasonable attorneys' fees and court costs in the event legal action is taken to collect on an account. The undersigned further agrees to pay an additional amount representing up to 40% of the principal balance if the account is referred to a collection agency or attorney for collections. This additional amount is in recognition of the cost associated with the said collection action processing.

I hereby authorize the physician(s) of Riverside Medical Arts to release any information acquired in the course of my examination to my insurance company, another physician or hospital, adjuster or attorney. I authorize payment directly to Riverside Medical Arts for surgical and/or medical benefits, if any, otherwise payable to me for services as described. I understand that I am financially responsible for all charges whether or not paid by my insurance company. A photocopy of this assignment of benefits shall be considered as effective and valid as the original. I also authorize the physician to initiate a complaint to the insurance commissioner for any reason on my behalf. Any lab testing done in the office or outside laboratory will be billed separately by the laboratory. I consent to any medical treatment deemed medically necessary by the provider. I understand that these treatments will be discussed with me and all questions will be answered before it is rendered.

SIGNATURE

Signature of Patient or Legal Guardian	Date mm / dd / yyyy

Patient Account # _____

ARBITRATION AGREEMENT

ARTICLE 1

Dispute Resolution

By signing this Agreement ("Agreement") we are agreeing to resolve any Claim for medical malpractice by the dispute resolution process described in this Agreement. Under this Agreement, you can pursue your Claim and seek damages, but you are waiving your right to have it decided by a judge or jury.

ARTICLE 2

Definitions

A. The term "we," "parties" or "us" means you, (the Patient), and the Provider.

B. The term "Claim" means one or more Malpractice Actions defined in the Utah Health Care Malpractice Act (Utah Code 78-14-3(15)). Each party may use the legal process to resolve non-medical malpractice claims.

C. The term "Provider" means the physician, group or clinic and their employees, partners, associates, agents, successors and estates.

D. The term "Patient" or "you" means:

(1) you and any person who makes a Claim for care given to YOU, such as your heirs, your spouse, children, parents or legal representatives, AND

(2) your unborn child or newborn child for care provided during the 12 months immediately following the date you sign this Agreement, or any person who makes a Claim for care given to that unborn or newborn child.

ARTICLE 3

Dispute Resolution Options

A. Methods Available for Dispute Resolution. We agree to resolve any Claim by:

(1) working directly with each other to try and find a solution that resolves the Claim, OR

(2) using non-binding mediation (each of us will bear one-half of the costs); OR

(3) using binding arbitration as described in this Agreement.

You may choose to use any or all of these methods to resolve your Claim.

B. Legal Counsel. Each of us may choose to be represented by legal counsel during any stage of the dispute resolution process, but each of us will pay the fees and costs of our own attorney.

C. Arbitration – Final Resolution. If working with the Provider or using non-binding mediation does not resolve your Claim, we agree that your Claim will be resolved through binding arbitration. We both agree that the decision reached in binding arbitration will be final.

ARTICLE 4

How to Arbitrate a Claim

A. Notice. To make a Claim under this Agreement, mail a written notice to the provider by certified mail that briefly describes the nature of your Claim (the "Notice"). If the Notice is sent to the Provider by certified mail it will suspend (toll) the applicable statute of limitations during the dispute resolution process described in this agreement.

B. Arbitrators. Within 30 days of receiving the Notice, the Provider will contact you. If you and the Provider cannot resolve the Claim by working together or through mediation, we will start the process of choosing arbitrators. There will be three arbitrators, unless we agree that a single arbitrator may resolve the claim.

(1) Appointed Arbitrators. You will appoint an arbitrator of your choosing and all Providers will jointly appoint an arbitrator of their choosing.

(2) Jointly-Selected Arbitrator. You and the Provider(s) will then jointly appoint an arbitrator (the "Jointly Selected Arbitrator"). If you and the Provider(s) cannot agree upon a jointly-Selected Arbitrator, the arbitrators appointed by each of the parties will choose the Jointly – Selected Arbitrator from a list of individuals approved as arbitrators by the state or federal courts of Utah. If the arbitrators cannot agree on a Jointly-Selected Arbitrator, either or both of us may request that a Utah court selects an individual from the lists described above. Each party will pay their own fees and costs in such an action. The Jointly Selected Arbitrator will preside over the arbitration hearing and have all other powers of an arbitrator as set forth in the Utah Uniform Arbitration Act.

C. Arbitration Expenses. You will pay the fees and costs of the arbitrator you appoint and the Provider(s) will pay the fees and costs of the arbitrator the Provider(s) appoints. Each of us will also pay one-half of the fees and expenses of the Jointly-Selected Arbitrator and any other expenses of the arbitration panel.

D. Final and Binding Decision. A majority of the three arbitrators will make a final decision on the claim. The decision shall be consistent with the Utah Uniform Arbitration Act.

E. All Claims May be Jointed. Any person or entity that could be appropriately named in a court proceeding ("Jointed Party") is entitled to participate in this arbitration as long as that person or entity agrees to be bound by the arbitration decision ("Joinder"). Joinder may also include Claims against persons or entities

Patient Account # _____

	that provided care prior to the signing date of this Agreement. A "Joined Party" does not participate in the selection of the arbitrators but is considered a "Provider" for all other purposes of this Agreement.
ARTICLE 5	**Liability and Damages May Be Arbitrated Separately** At the request of either party, the issues of liability and damages will be arbitrated separately. If the arbitration panel finds liability, the parties may agree to either continue to arbitrate damages with the initial panel or either party may cause that a second panel be selected for considering damages. However, if a second panel is selected, the Jointly Selected arbitrator will remain the same and will continue to preside over the arbitration unless the parties agree otherwise.
ARTICLE 6	**Venue / Governing Law** The arbitration hearings will be held in a place agreed to by the parties. If the parties cannot agree, the hearings will be held in Salt Lake City, Utah. Arbitration proceedings are private and shall be kept confidential. The provisions of the Utah Uniform Arbitration Act and the Federal Arbitration Act govern this Agreement. We hereby waive the pre litigation panel review requirements. The arbitrators will apportion fault to all persons or entities that contributed to the injury claimed by the Patient, whether or not those persons or entities are parties to the arbitration.
ARTICLE 7	**Term / Rescission / Termination** A. Term. This Agreement is binding on both of us for one year from the date you sign it unless you rescind it. If it is not rescinded, it will automatically renew every year unless either party notifies the other in writing of a decision to terminate it. B. Rescission. You may rescind this Agreement within 10 days of signing it by sending written notice by registered or certified mail to the Provider. The effective date of the rescission notice will be the date the rescission is postmarked. If not rescinded, this Agreement will govern all medical services received by the Patient from the Provider after the date of signing, except in the case of a Joined Party that provided care prior to the signing of this agreement (see Article 4 E). C. Termination. If the Agreement has not been rescinded, either party may still terminate it at any time, but termination will not take effect until the next anniversary of the signing of the Agreement. To terminate this Agreement, send written notice by registered of certified mail to the Provider. This Agreement applies to any Claim that arises while it is in effect, even if you file a Claim or request arbitration after the Agreement has been terminated.
ARTICLE 8	**Severability** If any part of this Agreement is held to be invalid or unenforceable, the remaining provisions will remain in full force and will not be affected by the invalidity of any other provision.
ARTICLE 9	**Acknowledgement of Written Explanation of Arbitration** I have received a written explanation of the terms of this Agreement and I have been verbally encouraged to read it and this Agreement. I have had the right to ask questions, I have been verbally encouraged to ask any questions, and I have had all my questions answered. I understand that any Claim I might have must be resolved through the dispute resolution process in this Agreement instead of having them heard by a judge or jury. I understand the role of the arbitrators and the manner in which they are selected. I understand the responsibility for arbitration related costs. I understand that this Agreement renews each year unless cancelled before the renewal date. I understand that I can decline to enter into the Agreement and still receive health care. I understand that I can rescind this Agreement within 10 days of signing it.
ARTICLE 10	**Receipt of Copy** I have received a copy of this document upon my request.

PROVIDER		
Name of Physician, Group or Clinic Southern Utah Surgical & Laser Aesthetics, LLC DBA: Riverside Medical Arts	Signature of Physician or Authorized Agent	Date mm / dd / yyyy
PATIENT		
Name of Patient	Signature of Patient or Patient's Legal Representative	Date mm / dd / yyyy

Patient Account # _____

RIVERSIDE MEDICAL ARTS

Allie Blazzard, FNP-C Benjamin Carter, MD Gayle M. Carter, MD

(435) 628-6466 ▪ Fax (435) 628-3845 ▪ Dermatology Fax (435) 986-9355
1068 E Riverside Dr. St. George, Utah 84790

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

ONGOING AUTHORIZATION TO RELEASE THE LABORATORY RESULTS OF			
First Name	Middle Initial	Last Name	Date of Birth mm / dd / yyyy
Address	City	State	Zip
Phone Number	Alternate Phone Number		

I the patient listed above hereby release Riverside Medical Arts and its staff from all legal responsibility that may arise from the release of the medical information hereby authorized. Once Riverside Medical Arts discloses my health information by my request, it cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information. This authorization will remain in effect until I provide written notice of revocation to Riverside Medical Arts.

SIGNATURE	
Signature of Patient or Legal Guardian	Date mm / dd / yyyy

Patient Account # _____

RIVERSIDE MEDICAL ARTS

PATIENT INFORMED CONSENT FOR

HORMONE SUPPLEMENTATION THERAPY

First Name	Middle Initial	Last Name	Date of Birth
			mm / dd / yyyy

I request and consent to the administration of hormones and oral supplements and authorize that these will be prescribed by the providers of Riverside Medical Arts. I acknowledge that there are no guarantees or assurances made with respect to the benefit of hormone supplementation therapy prescribed for me.

I understand that I will be in charge of injecting/administering these hormones and supplements prescribed to me. I will conform and comply with the recommended doses and methods of administration.

I understand that initial blood tests will be performed to establish my baseline hormone levels. I agree to comply with requests for ongoing testing to assure proper monitoring of my hormone levels. I agree to report to the providers any adverse reaction or problems that might be related to my hormone therapy. I understand that with hormone supplementation there are possible risks and complications if I do not comply with the recommended dosage.

I have not been promised or guaranteed any specific benefit from the administration of this therapy. I understand that hormone supplementation for rejuvenation purposes is a new specialty and there are no guarantees with respect to the treatment prescribed.

I have been advised that rectal/prostate exams and PSA (prostate specific antigen) blood test bare the standard of care for detection of early prostate cancer. I have been informed of the importance and necessity of these exams. I understand that my refusal to submit to these exams may result in cancer remaining undetected within my body. I acknowledge that I bear full responsibility for any personal injury or illness, accident, risk or loss (including death and/or prostate issues) that may be sustained by me in connection with my decision to refrain from these exams. I acknowledge and agree that I have been given adequate opportunity to review this document and to ask questions. I hereby release and agree to hold harmless treating Provider and any of their physicians, nurses, officers, directors, employees and agents from any and all liability, claims, demands and actions arising or related to any loss, property damage, illness, injury or accident that may be sustained by me as a result of my refusal to undergo rectal/prostate exams and PSA (prostate specific antigen) blood test.

I understand that the role of this health care provider is for hormone replacement only. I agree that I am and will continue to be under the care of another physician for regularly scheduled preventative visits and or any mental health/medical condition(s) I may currently have or may develop. I will provide Riverside Medical Arts with pertinent preventative care records and information regarding any medical condition(s) past or present.

I have been informed that insurance companies and Medicare may not pay for hormone supplementation therapy. I therefore agree to pay for all services including laboratory and pharmacy charges myself, with the understanding that I may not be reimbursed by my insurance company.

I have read and understand all of the above consent. I have had other information given to me about hormone supplementation therapy so that I fully understand what I am signing and hereby request and consent to treatment using hormone supplementation therapy.

***I understand that I am responsible to pay for all pellets and insertion fees, regardless of my insurance coverage or benefits. I understand that Riverside Medical Arts does not bill my insurance for these services and that I am required to pay at time of service.**

SIGNATURE OF PATIENT _____ **DATE** _____/_____/_____

SIGNATURE OF WITNESS _____ **DATE** _____/_____/_____

Patient Account # _____