LA

LiveAgelessly

8605 S. Eastern Ave Suite C1
Las Vegas, NV 89123

PATIENT INFORMATION

Thank you for choosing LiveAgelessly! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Check appropriate box: ☐Minor ☐Single ☐Engaged ☐Married ☐Separated ☐Divorced ☐Widowed

Gender: ☐Male ☐Female ☐Transgender

Patient Name: ________________________________Birthdate:_________________________________

Home Ph: _________________Cell Ph: ____________________SSN:______________________________

Address: ________________________________City:___________________State:_____Zip: ________

Patient's employer: ______________________Work:_______________Phone:_____________________

Business address: ________________________City: __________________State: _____ Zip: __________

Patient Occupation: ____

Spouse/Partners name: ____

Employer: __________________________ Work: _______________________Phone:_______________

Whom may we thank for referring you? ____

Person to contact in case of emergency: ____
Relation: ___________________ Phone: ________________

Personal Email _______________________________

Once available, would you like to receive the *LiveAgelessly* newsletter with health-related articles, information about upcoming seminars and workshops, and patient-only special events?

□Yes □No

Dr. Keller and the staff at *LiveAgelessly* are committed to maintaining the privacy of our clients' Protected Health Information, while providing high quality service. Please acknowledge by signing below that you are aware of our NOTICE OF PRIVACY PRACTICES. A photocopy can be furnished to you upon request.

I UNDERSTAND THAT *LIVEAGELESSLY* IS NOT CONTRACTED WITH AND THEREFORE DOES NOT BILL INSURANCE COMPANIES AND THAT I AM RESPONSIBLE FOR ALL FEES AND THAT ALL CHARGES ARE DUE AT THE TIME OF SERVICE.

X____

SIGNATURE **DATE**

LA

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Welcome to LiveAgelessly

We are excited to have you as a patient. It is our promise to try and provide you with the best solution(s) to treat hormonal decline. At LiveAgelessly we want to provide you with bioidentical hormones (BHRT) that are required for your particular needs based upon your symptoms. Using your labs as a road map to guide your therapy, Dr. Keller makes every attempt to get and keep your hormones balanced. She will determine the dosage of BHRT that is best for your individual needs. For some of you this may not be your first time seeing a practitioner for hormone replacement therapy. Please make certain to provide Dr. Keller with information regarding prior use of any hormone replacement therapy. For others this may be your first time seeing someone. Dr. Keller's goal is to not only use hormones, but also to emphasize the importance of proper nutritional supplementation. We recommend only the best nutraceutical grade supplements that have proven themselves both scientifically and clinically in making our patients feel better. **(Please initial at the end of each section).**

Initial Appointments

Please read and complete all patient forms prior to your first appointment. It is highly recommended that you complete your paperwork prior to your appointment. You may fax or email the ***Medical History Questionnaire*** prior to your appointment or bring it to the office on the day of your appointment. If you are unable to complete your paperwork prior to your appointment, we advise that you to arrive a minimum of 30 minutes prior to your appointment to complete all required paperwork. Dr. Keller does not double book appointments. We prefer that our patients not lose any appointment time filling out paperwork. Paperwork not completed by the beginning of your appointment will need to be completed during your appointment time and your initial consult with Dr. Keller may be shortened or rescheduled. If you have not completed your paperwork by 15 minutes past the time of your scheduled appointment, you will need to be rescheduled. You will be charged for the appointment time. If you have many issues that need to be addressed and have a complicated history, it is strongly encouraged that you do one of our packages to give you a full hour for your first consultation. If for some reason your appointment extends over your original scheduled time you may be offered more time, but at the regular non-discounted rate. Extension of an appointment may not be possible if it delays the care to patients with already scheduled appointments. **Please keep in mind that you have 90 days from your initial appointment to have your bloodwork done and come in for your 6-week follow-up. If you go past that time. You will forgo your included follow-up visit.** If this were to occur, you would be rescheduled to return for a follow-up visit. **_______ (Initials)**

Late Appointments

Patient satisfaction is our number one priority. We ask in order to best serve you that you also make us your priority by being on time to all appointments. In return Dr. Keller promises to make every effort to stay on schedule as we value your time as well and understand that you also have a schedule that you follow. If at all possible, we suggest that you arrive 10 minutes early to address administrative needs. If you are late for an appointment, this time will come from your allotted time. For example, if you are 10 minutes late to a 60 minute appointment, you will be charged for the entire 60 minute appointment time allocated to you, even if your actual time with Dr. Keller is 50 minutes. If Dr. Keller is running late due to an unforeseen patient need or an in office or out of office emergency, our office staff will notify you if at all possible and you will receive your full allotted time. If for some unforeseen reason you cannot be seen within a reasonable time frame, you would be contacted and your appointment rescheduled. Please understand that this policy has been put in place so that you not only receive exceptional care, but so that other patients don't make you wait when you have shown on time for your scheduled appointment. **_______ (Initials)**

Cancellations, Missed Appointments, & Rescheduling

At times we may have a waiting list of patients who would like to see Dr. Keller sooner than their scheduled appointment. We are typically booked at least 3 weeks in advance and sometimes longer. We require that all patients give a minimum of 72 hours' notice, to cancel or reschedule appointments. In order to avoid having to increase our fees or shorten appointments and squeeze in more patients, each patient is required to pay for any appointment missed, late or cancelled without the required notification time of 3 business days. We ask that all cancellations or rescheduled appointments be done during regular business hours to allow us ample time to offer the appointment time to another patient. If an appointment is cancelled or rescheduled without required notice, our staff will attempt to fill the appointment. If the appointment does not get filled, you will be charged for the missed/cancelled appointment and you will not be rescheduled until the fee is paid. Please note our staff usually attempts to remind you by phone two days before your appointment; however we do not guarantee reminder calls and it is your responsibility to remember your appointment time and date. Rescheduling an appointment twice in a row or multiple rescheduling of appointments may result in discharge from the practice, unless if there is a reasonable excuse. Please sign below indicating that you have read and agree to this policy.

____

Signature   Date

New Patient Security Deposit

Unfortunately, it has become necessary for our office to secure first time appointments with a credit card number or personal check. Unlike the standard health care model, Dr. Keller has chosen to see only a limited number of patients in her office per day in order to spend more time with each patient to thoroughly address individual health care needs and goals. In addition, we choose not to charge membership fees as done in other clinics offering similar treatment.

If you are a new patient, you are required to provide a credit card number with expiration date, **which will be charged** $450 when you book your initial consultation. If you cancel less than 72 hours' notice or miss your first appointment there is a non-refundable fee of $150 dollars. All cancellations or rescheduling requests must be made by phone to our office. Messages left on our answering machine or service will be accepted if left at the lunch hour or 72 hours prior to a scheduled appointment. Also, by scheduling a consultation you agree to have your initial lab work completed within 3 weeks from your first appointment.

New patients must read and sign below: I, the cardholder named below, authorize *LiveAgelessly* to use the credit card information provided in the event of cancellation without **72 hours' notice,** or in the event that I, the patient so named below, do not appear at the office of *LiveAgelessly* on the date and time of my scheduled appointment.

____ ______________________________________
Signature Date

Laboratory Testing

Labs are ordered at your first visit. After which all labs are ordered prior to your appointments. Please make every effort to have them done in time so that your treatment plan can be initiated. Once your results are in, someone from LiveAgelessly will call and schedule your appointment. **We make no guarantees that the labs ordered by our office will be covered by insurance & LiveAgelessly will not correspond with your insurance company or the laboratory. In order to avoid high laboratory fees we recommend using our preferred laboratory True Health Diagnostics.** We also encourage all our patients to know their laboratory benefits before any lab work is drawn. As a courtesy to you, we will email/mail **ONE (1)** lab slip. If you REQUIRE an additional lab order there will be a $25.00 administration fee. **_______ (Initials)**

Prescriptions

Prescriptions are faxed to both compounding pharmacies and/or regular pharmacies, depending upon what is best for each patient. Prescriptions often are covered by insurance companies based upon an individual's health plan coverage. Dr. Keller does not know if an insurance company will cover medications prescribed or how much they will cost. **LiveAgelessly does not check on prescriptions benefits**. This helps to keep our prices affordable. For prescription refills, please allow 72 business hours for completion. **All prescriptions are faxed to the pharmacy unless if you desire a printed prescription. _______ (Initials) Please list the name and cross streets of a regular pharmacy that you would want prescriptions faxed to (i.e. Walgreens Eastern & Sunridge Heights):**

Insurance Policy

LiveAgelessly is not contracted with any insurance company and does not bill insurance companies. We have a philosophy regarding health care that does not follow the "standard of care" approach for only treating patients that fit a set strict criterion of "sickness" before treatment can be initiated. Our philosophy does not follow the care guidelines put forth by the insurance industry. The goal at *LiveAgelessly* is the prevention of disease, as this is actually easier than waiting until the body completely falls apart before a treatment is initiated. Many people develop symptoms far before a disease process ensues.
If you submit a claim to your insurance company and they request chart notes or any other information that require Dr. Keller to fill out a form, **the fee for handling these issues is $25. _______ (Initials)**

Lab Results, Chart Notes and Release of Records

Dr. Keller will provide you with a copy of your lab results at the time of your appointment. If you would like us to fax your lab results and/or chart notes to another physician, we will gladly do so at **no charge to you**, simply ask our receptionist for a release of records form and we will fax your records. If you want a personal copy of your chart notes there is a $0.60 per page fee and any postage that might be required, if they are being mailed. **_______(Initials)**

Phone Calls/Virtual Appointments

If you have questions or concerns and you cannot wait until your scheduled appointment, feel free to contact our office directly by phone. Telephone consults can also be done via Skype these are what we refer to as *"virtual office visits."* This gives our patients flexibility if they are out of town and need access to health care. *Virtual office visits* are scheduled on an individual basis depending upon individual needs and what makes the best sense for your health. In other words, some people will require visits that can only be done in the office, as they require physical contact, i.e. a pellet insertion. Fees are not much different than office visits as they are based on time. **______(Initials)**

Email

Dr. Keller prefers to avoid email communication in regards to direct patient care. You are better served by discussing your situation directly with Dr. Keller either in person, by phone or with a virtual appointment. Non-medical related issues with the staff in regard to booking appointments, general information, feedback, etc. will be addressed on a daily basis. In general, emails are an effective way to communicate with the office, but **if you have not heard back from our office staff within 24 hours, please call us.**

Nutraceutical/Supplements

Dr. Keller will make recommendations for supplements. At LiveAgelessly, we offer you high quality supplements that have been proven to help benefit the health of our patients. Our supplement recommendations may change from time to time as we look for the best quality affordable products.

Notice of Privacy Rights

We are committed to maintaining the privacy of our clients' Protected Health Information (PHI), while providing high quality service. In accordance with the HIPAA regulations all patients will receive a full written notice of our client's privacy practices at their first office visit after April 2007 that will explain:

- Your privacy rights regarding your PHI.
- Our obligations concerning the use and disclosure of your PHI.

Indicate below any persons authorized to discuss your PHI with our office. Include the person's name and relationship to yourself. Include a start date and an end date to set restrictions for any individual(s).

Name	Relationship	Start Date	End Date
______________________________	____________		____________________
_________________________________	____________		____________________

These are your rights as they relate to your PHI. Please initial and acknowledge having read the **Notice of Privacy Practices.** A copy can be furnished to you on request. **_______ (Initials)**

Live Agelessly
8605 S. Eastern Ave. Suite C
Las Vegas, NV 89123
Phone: (702)546-5483

NAME: _______________________________ DATE OF BIRTH: ___________________ TODAY'S DATE: ________________

MENOPAUSE RATING SCALE (MRS)

Which of the following symptoms apply to you at this time? (*CHECK ONE BOX & CIRCLE APPLICABLE DESCRIPTION*).

Symptoms: Rating Scale:	NONE	MILD	MODERATE	SEVERE	EXTREMELY SEVERE
1) Hot Flashes: A. Episodes of Sweating B. Night Sweats…………………	☐	☐	☐	☐	☐
2) Heart Discomfort: A. Unusual Awareness of Heart Beat B. Heart Racing C. Tightness D. Heart Skipping…………………………………	☐	☐	☐	☐	☐
3) Sleep Problems: A. Difficulty in Sleeping Through the Night B. Waking Up Early	☐	☐	☐	☐	☐
4) Depressive Mood: A. Feeling Down B. Sad C. On the Verge of Tears D. Lack of Drive E. Mood Swings…………………………………	☐	☐	☐	☐	☐
5) Irritability: A. Feeling Nervous B. Inner Tension C. Feeling Aggressive………………………………………….…...…	☐	☐	☐	☐	☐
6) Anxiety: A. Inner Restlessness/Anxious B. Panicky…………………………….….…	☐	☐	☐	☐	☐
7) Physical & Mental Exhaustion: A. General Decrease in Performance B. Impaired Memory C. Decrease in Concentration D. Brain Fog/Forgetfulness………………	☐	☐	☐	☐	☐
8) Sexual Health: A. Lack of Desire B. Change in Activity C. Change in Satisfaction……………………………….………….……	☐	☐	☐	☐	☐
9) Vaginal Health: A. Dryness of Vagina B. Difficulty with Intercourse C. Dryness or Burning During Intercourse………………….....………	☐	☐	☐	☐	☐
10) Bladder Problems: A. Difficulty Urinating B. Increased Need to Urinate C. Bladder Incontinence……………………………...….……………	☐	☐	☐	☐	☐
11) Musculoskeletal: A. Joint Discomfort/Pain B. Muscular Discomfort/Pain C. Rheumatoid Discomfort/Pain……………………...…………	☐	☐	☐	☐	☐

****

FOR OFFICE USE ONLY

Please circle which applies to THIS questionnaire. **Baseline or Follow-Up**

Baseline ☐ No hormone Therapy ☐ Hormone Therapy (Other than Pellet Therapy) ☐

Testosterone Pellet Dose________________________ Date Implanted______________________________

Additional Hormone Therapy_____________________________________ Date Started________________

Pre-Menopausal ☐ Post-Menopausal ☐ Partial Hysterectomy ☐ Total Hysterectomy ☐

Live Agelessly
8605 S. Eastern Ave. Suite #C
Las Vegas, NV 89123
Ph: 702-546-5483
Fax: 702-252-3000

Mammogram Exam Waiver For Hormone Therapy

Date: ______________

I, ___________________________ voluntarily choose to undergo hormone therapy. For today's appointment, I have not provided you with a recent mammogram report.

___ Due to I wish not to have mammogram exams

___ I will provide a copy of my most recent mammogram report at my next visit.

___ I have included a copy with my new patient paperwork

I am aware that the purpose of the mammogram exam is the detection of breast cancer.

I agree that if any breast cancer develops while on hormone therapy, I release Maria Keller M.D. FACOG from any liability.

Signature: _________________________________

Printed Name: ________________________________

LiveAgelessly
8605 S. Eastern Ave. Suite #C
Las Vegas, NV 89123
Ph: 702-546-5483
Fax: 702-252-3000

LAB WORK WAIVER

Labs are ordered at your first visit. After which all labs are ordered prior to your appointments. Please make every effort to have them done in time so that your treatment plan can be initiated. Once your results are in, someone from LiveAgelessly will call and schedule your appointment.

We make no guarantees that the labs ordered by our office will be covered by insurance & LiveAgelessly will not correspond with your insurance company or the laboratory. In order to avoid high laboratory fees, we recommend to check with your health insurance Prior to having labs drawn. We also encourage all our patients to know their laboratory benefits before any lab work is drawn.
*Please keep in mind that there is a $25 fee for all replacement lab slips.

I understand that LiveAgelessly is not responsible for any laboratory expenses and does not guarantee that lab work will be covered by insurance.

Signature: ____ **Date:**________________

Patient Name (Print): ____

FEMALE MEDICAL HISTORY
PLEASE PRINT

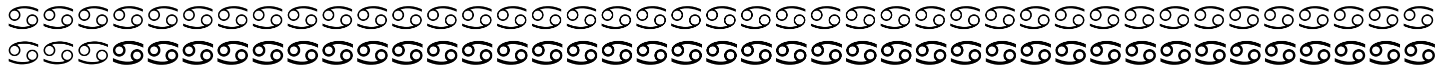
Today's Date: ______________________

Name: ____________________________________ **Birthdate:** _____________ **Age:** _____

Address: ____

City: ___________________________________ **State:** _____ **Zip:** __________________

Phone: _______________________________ **E-Mail Address:** _______________________



Height: _________ **Weight:** _________

			How often and how much?
Do you use tobacco?	☐ Yes	☐ No	____
Do you use alcohol?	☐ Yes	☐ No	____
Do you use caffeine?	☐ Yes	☐ No	____

Doctor's Name: **Address:** **Phone:**_______________

____

____

____

Allergies: Please check all that apply. ☐ **I HAVE NO ALLERGIES**

___ **penicillin** ___ morphine ___ dye allergies ___ pet allergies
___ codeine ___ aspirin ___ nitrate allergy ___ seasonal (pollen) allergies
___ sulfa drug ___ food allergies ___ other: ____

Please describe the allergic reaction you experienced and when it occurred?

____

____

____

Medical Conditions/Diseases: Please check all that apply to you.

___ Heart disease (example: Congestive Heart Failure)
___ High cholesterol or lipids (examples: Hyperlipidemia)
___ High blood pressure (example: Hypertension)
___ Cancer –list type: ____________________________
___ Ulcers (stomach, esophagus)
___ Thyroid disease, list type: ____________________
___ Sleep Apnea – do u use CPAP? ________
___ Lung condition (example: asthma, emphysema, COPD)
___ Other: Please list: ___________________________

___ Blood Clotting Problems
___ Diabetes
___ Arthritis or joint problems
___ Depression
___ Anxiety
___ Headaches/migraines
___ Eye Disease (glaucoma, etc.)
___ Epilepsy

____

____

Surgical History: Check all that apply **Why?** **When?**

___ Abdominal Hysterectomy, ovaries NOT removed ____________________ __________

___ Abdominal Hysterectomy, ovaries removed ____________________ __________

___ Vaginal hysterectomy or LAVH, ovaries NOT removed ____________________ __________

___ Vaginal hysterectomy or LAVH, ovaries removed ____________________ __________

___ Gallbladder ____________________ __________

___ Other Please list: ____

____

____

Over-the-counter (OTC) medications:

Please check all products that you use occasionally or regularly. Check all that apply.

___ Pain Reliever

___ Aspirin

___ Acetaminophen (example: Tylenol®)

___ Ibuprofen (example: Motrin IB®)

___ Naproxen (example: Aleve®)

___ Ketoprofen (example: Orudis KT®)

___ Antihistamine (example: Chlor-Trimeton®)

___ Decongestant product (example: Sudafed ®)

___ Sleep aids (exmples: Excedrin PC®, Unisom®, Sominex®, Nytol®)

___ Antidiarrheal (examples: Imodium®, Pepto Bismol®, Kaopectate®)

___ Laxatives/stool softeners (examples: Doxidan®, Correctol®, etc.)

___ Diet aids/weight loss products (example: Dexatril®)

___ Antacids (examples: Maalox®, Mylanta®)

___ Acid blockers (examples: Tagamet HB®, Pepcid C®, Zantac 75®)

___ Other (please list)

____

Nutritional/Natural Supplements: Please identify and list the products you are using:

☐ vitamins (examples: multiple or single vitamins such as B complex, E, C, beta carotene)

☐ minerals (examples: calcium, magnesium, chromium, colloidal minerals, various single minerals)

☐ herbs (examples: Ginseng, Ginkgo Biloba, Echinacea, other herbal medicinal teas, tinctures, remedies, etc.)

☐ enzymes (examples: digestive formulas, papaya, bromelain, CoEnzyme Q10, etc.)

☐ nutrition/protein supplements (examples: shark cartilage, protein powers, amino acids, fish oils, etc.)

☐ others (glucosamine, etc.) Please list: ____

____

____

Current Prescription Medications:

Medication Name Dose & how often per day Reason

____

____

____

____

____

____

List Hormones previously taken. Date Started Date Stopped Why? Side Effects?

____

____

____

____

Have you ever used oral contraceptives? ☐ No ☐ Yes

Any problems? ☐ No ☐ Yes

If YES, describe any problem(s).

____

____

How many pregnancies have you had? _____

How many children? _____

How many vaginal births? _____

How many cesareans? _____

How many miscarriages? _____

How many abortions? _____

What do you do to avoid a pregnancy: check any that apply:

- ☐ Menopausal
- ☐ Tubal Ligation or Essure Tubal Occlusion
- ☐ Vasectomy
- ☐ Mirena IUD, how long? ___
- ☐ Pull and pray
- ☐ Hysterectomy
- ☐ hormonal contraceptive, i.e. pills
- ☐ condoms
- ☐ Copper IUD, how long? ___
- ☐ Other: ____________

Do you have a family history of any of the following?

Uterine Cancer	_____	Family member(s)	____________________________________
Ovarian Cancer	_____	Family member(s)	____________________________________
Fibrocystic breast	_____	Family member(s)	____________________________________
Breast Cancer	_____	Family member(s)	____________________________________
Heart Disease	_____	Family member(s)	____________________________________
Osteoporosis	_____	Family member(s)	____________________________________
Colon Cancer	_____	Family member(s)	____________________________________
Thyroid Disease	_____	Family member(s)	____________________________________
Diabetes	_____	Family members(s)	____________________________________

Have you had any of the following tests performed?

Mammogram	☐ No	☐ Yes	Date: _________	Normal result: Yes or No
PAP Smear	☐ No	☐ Yes	Date: _________	Normal result: Yes or No
Colonoscopy	☐ No	☐ Yes	Date: _________	Normal result: Yes or No

Menopausal women only:
How old were you when you had your last menstrual cycle ever? __________

Menstruating women only:
Last menstrual cycle date: _________ Do you consider your cycles to be abnormal cycles?
☐ No ☐ Yes

If Yes, please explain: ____

____

____

____

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 BHRT?

____
____
____
____

Please write down any questions you have about Bio-identical Hormone Replacement Therapy.

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