

Date: _____

Name: _____ DOB: _____ Age: _____

Phone Number: _____ Email Address: _____

I am interested in:

BIO-IDENTICAL HORMONE THERAPY REPLACEMENT

Have you done hormone replacement before? Y / N Currently on: Y / N

If currently on it, what type of therapy: OTC Creams Orals Patches Pellets

If you are currently on pellet therapy, why are you leaving: _____

List any past therapies you have done: OTC Creams Orals Patches Pellets

Have you had a hysterectomy: Y / N Ovaries removed: Y / N

Have you had a uterine ablation: Y / N Tubes Tied: Y / N

Do you currently have cycles: Y / N Are they regular: Y / N Are they heavy: Y / N

Do you have an IUD: Y / N

VAGINAL REJUVENATION

What type of symptoms are you having?

Stress Urinary Incontinence (Leakage when cough, sneeze, lifting etc)

Laxity

Dryness

Desire

How did you hear about us?

Google

Facebook

Physician _____

Friend: _____

Prior Patient

DATE: _____

FOR OFFICE USE ONLY	
BP: _____	WT: _____
HT: _____	
ALLERGIES: _____	

**TIRPACK MEDICAL PROCEDURES
PATIENT REGISTRATION SHEET**

Patient Name: _____ Maiden/Other Name: _____

BirthDay: _____ Sex: _____ Social Security Number: _____ Race: _____

Street Address: _____ City/State: _____ Zip: _____

Cell Number: _____ Home Number: _____ Marital Status: _____

Pharmacy Name: _____ Pharmacy Number: _____

Patient Email Address: _____

Patient Employer: _____ Employer Phone: _____

Employer's Address: _____ City/State: _____ Zip: _____

Patient Occupation: _____

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

Effective April 14, 2003 (Due to federal guidelines under HIPPA) we are now required to have a release form signed by patient before we can give out any medical or financial information to any person other than the patient.

Please list below the names, relationship, and phone numbers of any authorized individuals (spouse, family members, friends, caregivers, etc;) that we may discuss your medical or financial information with:

Name	Relationship	Phone Number	Emergency Contact Yes or No
1. _____			
2. _____			
3. _____			

May we leave medical information on your cell or home voice mail? Yes _____ No _____

Signature of Patient/Parent: _____

If you DO NOT want any medical or financial information discussed with anyone other than yourself please sign here:

Signature of Patient/Parent: _____

DATE: _____

INSURANCE INFORMATION SHEET
(Please Print)

FOR OFFICE USE ONLY	
BP: _____	WT: _____
HT: _____	
ALLERGIES: _____	

INSURANCE INFORMATION		
Primary Insurance _____	Policy _____	Group # _____
Effective Date _____	Expiration Date _____	Relationship to Patient _____
Subscribers Name _____	Subscribers DOB _____	
Secondary Insurance _____	Policy _____	Group # _____
Effective Date _____	Expiration Date _____	Relationship to Patient _____
Subscribers Name _____	Subscribers DOB _____	

CONSENT FOR HEALTHCARE SERVICES:

Initial: _____

I hereby, authorize my physician or clinic staff to provide treatment, maintenance, care, and test diagnostic procedures, x-rays, surgical and medical treatments as may be necessary for the preservation or protection of my health, safety, and well being. I understand that no guarantees have been given as to the effectiveness or outcome of any treatment or procedure rendered. I intelligently, voluntarily and freely give my consent or warrant that I am legally authorized to give consent on behalf of the patient.

AUTHORIZATION TO RELEASE INFORMATION:

Initial: _____

I authorize my physician or clinic staff to release medical records, related medical information and charge information for my outpatient/clinic visit for the purpose of further medical treatment and determining insurance coverage and medical payment owed to clinic/hospital charges, including but not limited hospital or medical service companies, insurance companies, workers compensation earners, or welfare funds. I certify that the information given by me in applying for payment under title XVIII and XIX of the social security act is correct. I authorize any holder of medical information given by me to release to the Social Security Administration or its intermediaries or the Medicaid agency or its intermediaries any information needed for the Medicare or Medicaid claim. I consent to the release of information including psychiatric drug, alcohol and substance abuse records. I consent to the release of information of any specialist in the event of my physician refers me.

ASSIGNMENT OF BENEFITS (If covered by insurance)

Initial: _____

I direct that my insurance company pays the benefits for this treatment directly to the clinic. I assign to the clinic/hospital for the purpose of security, any right I may have to receive such payment directly from the insurance company, and hereby revoke any prior authorizations which I may have given to the contrary. I agree to cooperate fully with the clinics efforts to obtain payment under such policy and will execute any additional documents my insurance company may require in order to process the clinics claim. In the event of any overpayment of insurance benefits, (as where two policies are subject to a coordination of benefits) I authorize the clinic to refund to the company making such overpayment.

FINANCIAL RESPONSIBILITY

Initial: _____

I understand by signing below, I AGREE TO PAY THE CLINICAL BILL for the services rendered, whether or not I am the patient. I agree that I will pay this bill in full whether or not charges are or should have been covered by insurance. I have been advised that the clinic does not extend credit and that payment is due in full at time of service. I agree that if this account is not paid when due, and if the clinic refer to an attorney for collection, I will pay all costs of collection including interest, and a reasonable attorney's fee (even if suit is not filed) I hereby waive all rights of exemption which are available to me under the laws of Alabama or of the united states.

CANCELLATION POLICY FOR PELLETT INSERTION

Initial: _____

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to the seemingly "full" appointment book. Dr. Tirpack wants to be available for your needs as well as the needs of all our other patients. By respectfully calling our office 24 business hours before scheduled appointment; it gives us plenty of time to refill the reserved time. We have a list of patients that need or want in sooner and this time frame will allow our staff to do this. **EFFECTIVE JANUARY 1, 2018, if an appointment is not cancelled at least 24 business hours in advance, you will be charged a \$25 fee.**

Signature of Patient _____

Date _____

FOR OFFICE USE ONLY
 BP: _____ WT: _____
 HT: _____
 ALLERGIES: _____

DATE: _____

FEMALE MEDICAL HISTORY FORM

NAME: _____ PRIMARY CARE PHYSICIAN: _____
 OCCUPATION: _____ REFERRED BY: _____

MAIN REASON FOR VISIT _____
 HAVE YOU EVER DONE HORMONE REPLACEMENT BEFORE? _____ IF SO, WHERE: _____

OBSTETRICAL HISTORY

LIST ALL PREGNANCIES (INCLUDING MISCARRIAGES, ABORTIONS, ETC.)

YEAR	LENGTH OF PREGNANCIES	HOSPITAL	COMPLICATIONS	BIRTH WEIGHT	SEX	GESTATIONAL DIABETES
1. _____	_____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____	_____

SURGICAL HISTORY

LIST ALL SURGERIES SURGERY

HOSPITAL

1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

MEDICATIONS

PLEASE LIST ALL MEDICATIONS AND DOSE (INCLUDING VITAMINS AND SUPPLEMENTS)

DRUG ALLERGIES:

HABITS

HAVE YOU EVER OR DO YOU CURRENTLY?

- SMOKE _____
- RECREATIONAL DRUGS _____
- DRINK ALCOHOL _____
- EXERCISE _____

FAMILY HISTORY

DO YOU HAVE ANY RELATIVES WITH ANY OF THE FOLLOWING?

- HIGH BLOOD PRESSURE _____
- HEART DISEASE _____
- DIABETES _____
- BREAST CANCER, WHO _____
- ANY OTHER TYPE OF CANCER _____

GYNECOLOGICAL HISTORY

FIRST DAY OF LAST CYCLE _____
 AGE WHEN YOU STARTED _____
 HOW MANY DAYS DO YOU FLOW _____
 DATE OF LAST PAP _____
 WHERE WAS IT DONE _____
 HAVE YOU HAD A HYSTERECTOMY _____

BIRTH CONTROL _____
 CURRENT METHOD _____
 PREVIOUS METHOD _____
 MAMMOGRAM _____
 DATE OF LAST MAMMOGRAM (MM/YY) _____
 WHERE WAS IT DONE _____

PAST MEDICAL HISTORY

PLACE AN "X" NEXT TO ANY OF THE FOLLOWING CONDITIONS YOU HAVE OR HAVE EVER HAD

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> PAINFUL CYCLES | <input type="checkbox"/> DIABETES | <input type="checkbox"/> HEART TROUBLE | <input type="checkbox"/> PSYCHIATRIC CARE |
| <input type="checkbox"/> BREAK THROUGH BLEEDING | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> HEART MURMURS | <input type="checkbox"/> BONE PROBLEMS |
| <input type="checkbox"/> IRREGULAR CYCLES | <input type="checkbox"/> MITRAL VALVE PROLAPSE | <input type="checkbox"/> ANEMIA | <input type="checkbox"/> MUSCLE PROBLEMS |
| <input type="checkbox"/> ABNORMAL PAP | <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> BLOOD TRANSFUSION | <input type="checkbox"/> BREAST DISEASE |
| <input type="checkbox"/> GENITAL WARTS | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> ELEVATED CHOLESTEROL | <input type="checkbox"/> ASTHMA |
| <input type="checkbox"/> STD'S | <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> CHEST PAIN | <input type="checkbox"/> EMPHYSEMA |
| <input type="checkbox"/> PELVIC INFECTION | <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> GALLBLADDER PROBLEMS | <input type="checkbox"/> FAINTING SPELLS |
| <input type="checkbox"/> INVOLUNTARY URINE LOSS | <input type="checkbox"/> THYROID PROBLEMS | <input type="checkbox"/> YELLOW JAUNDICE (HEPATITIS) | <input type="checkbox"/> CONVULSIONS |
| <input type="checkbox"/> PAINFUL INTERCOURSE | <input type="checkbox"/> EPILEPSY/SEIZURES | <input type="checkbox"/> ULCERS | <input type="checkbox"/> RECENT WT CHANGES |
| <input type="checkbox"/> PNEUMONIA | <input type="checkbox"/> PHLEBITIS (BLOOD CLOTS) | <input type="checkbox"/> BLOODY STOOLS OR VOMITUS | <input type="checkbox"/> OSTEOPOROSIS |
| <input type="checkbox"/> SEXUAL/MARITAL PROBLEMS | <input type="checkbox"/> MIGRAINES/HEADACHES | <input type="checkbox"/> BOWEL HABIT CHANGES | <input type="checkbox"/> OSTEOARTHRIS |
| <input type="checkbox"/> ABUSE/VIOLENCE | <input type="checkbox"/> DIGESTIVE DISORDER | <input type="checkbox"/> COLITIS OR SPASTIC COLON | |
| <input type="checkbox"/> BREAST PROBLEMS | <input type="checkbox"/> HYPERTENSION | <input type="checkbox"/> KIDNEY INFECTION | |
| <input type="checkbox"/> NIPPLE DISCHARGE | <input type="checkbox"/> ALLERGIES | <input type="checkbox"/> BLADDER INFECTION | |
| <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> CANCER | <input type="checkbox"/> BLOOD IN URINE | |
| <input type="checkbox"/> FEELING THAT PELVIC ORGANS ARE FALLING OUT | | <input type="checkbox"/> OTHER _____ | |

FEMALE SYMPTOM RATING CHART

Jill Tirpack, M.D., M.P.H., F.A.C.O.G

Date of Insertion: _____

Name: _____ Phone #: _____

Email Address: _____ Pharmacy #: _____

Age: _____ Wt: _____ Ht: _____ Allergies: _____

Hysterectomy: () yes () no If yes, when? _____ Last Mammogram? _____

If you have experienced any of the following symptoms, please check below:

PRE-INSERTION

POST-INSERTION

	MILD	BAD	SEVERE		SAME	IMPROVING	GONE
Mood Changes/Irritability				Mood Changes/Irritability			
Tension				Tension			
Brain Fog/Memory Loss				Brain Fog/Memory Loss			
Fatigue				Fatigue			
Decreased Sex Drive				Decreased Sex Drive			
Mental Confusion				Mental Confusion			
Depression				Depression			
Sleep Loss				Sleep Loss			
Migraines/Severe Headaches				Migraines/Severe Headaches			
Hot Flashes				Hot Flashes			
Night Sweats				Night Sweats			
Vaginal Dryness				Vaginal Dryness			

LAB WORK

Pre-Insertion

Insert #1

4 Wk Post Insert

12 Wk Post Insert

Date _____

Date _____

Date _____

Date _____

Testosterone _____

T: _____

Testosterone _____

Testosterone _____

FSH _____

E2: _____

FSH _____

FSH _____

E2 _____

P4: Y / N

E2 _____

E2 _____

TSH _____

Dose: _____

P4: _____

P4 _____

Vitamin D _____

Other _____

Vitamin D _____

Vitamin B12 _____

Vitamin B12 _____

P4: _____

Other: _____

Other _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ Date of Birth: _____

Phone Number (Cell): _____ Phone Number (Home): _____

Address: _____ City/State/Zip: _____

Dates and Type of information to disclose:

2 years prior from last date seen

Specific Information Requested _____

Dates Other: _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release From:

Company Name: _____

Address: _____

City, State, Zip: _____

Phone #: _____

Fax #: _____

Release To: Dr. Jill Tirpack

Tirpack Medical Procedures

2057 Valleydale Road, Ste 210

Hoover, AL 35244

Phone: (205) 822-0212

Fax: (205) 822-0214

Please mail records

Please fax records to (205) 822-0214

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition:** _____.

If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of the authorization.

Signature of Patient/Parent/Guardian or Authorized Representative

Date