The Institute for Hormonal Balance

Financial Policy, Insurance Policy, Releases and Waiver

Thank you for choosing The Institute for Hormonal Balance. As we request you read and sign the following financial policy prior to treatment. Patient or responsible party must complete our information form before seeing Dr. Edwin Lee and/or any Associate with The Institute for Hormonal Balance.

• **FULL PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.** We accept Cash, Visa, MasterCard, American Express & Discover. **You will be expected to pay in full for services provided.**

____________**Initial**

1. Office Policy:

- We do not accept any form of insurance as payment for any part of your visit. However, as a courtesy your receipt will show all the charges and proper diagnosis codes for you to file with your insurance for possible reimbursement. We do work with some labs that will file your insurance for you for some of the advanced testing Dr. Lee may order. However you are the final responsible party for payment if your claim is denied.

____________**Initial**

- Dr. Edwin Lee and/or Associates with The Institute for Hormonal Balance require a $500 reservation fee in order to secure your appointment. If you need to reschedule or cancel your appointment with us, we require a 48 business hour notice. Failure to give our office a 48 business hour notice will result in you forfeiting your reservation fee to Dr. Lee and/or any associate with The Institute for Hormonal Balance.

____________**Initial**

- 48 business hours are required to cancel or reschedule follow up appointments with Dr. Lee and/or any associate with The Institute for Hormonal Balance. If you are unable to give us a 48 business hour notice we reserve the right to charge you a $200 missed appointment/cancellation fee.

____________**Initial**

- Dr. Edwin Lee and/or Associates with The Institute for Hormonal Balance do not accept disability.

____________**Initial**

- Dr. Edwin Lee and/or Associates with The Institute for Hormonal Balance do not guarantee to cure any medical condition.

____________**Initial**

- Dr. Edwin Lee and/or Associates with The Institute for Hormonal Balance have no hospital privileges, so we are not able to admit or consult with you while you are in the hospital.

____________**Initial**

- Dr. Edwin Lee and/or Associates with The Institute for Hormonal Balance are not your primary care doctor. If you have any serious acute medical condition (for example chest pain, shortness or breath, acute bleeding, or severe headaches) then go to the emergency room and call your primary care physician.

____________**Initial**

- Dr. Edwin Lee and/or Associates with The Institute for Hormonal Balance cannot provide service after normal business hours 8:30 to 4:30 Monday thru Friday. If you have an issue please call during business hours so that we can help you**.**

____________**Initial**

- As for any laboratory tests, Vo2 max testing, EEG neurobiofeedback, DEXA scan, Bioelectrical Impediance Analysis, whole body composition, aqua detox, relaxation on the hydro massage table, or IV supplementation, this may or may not be covered by your insurance. You can submit your bill to your insurance company to be reimbursed. There is no guarantee that this will be covered.

____________**Initial**

2. Minor Patients (under the age of 18):

- The adult accompanying a minor (patient/guardian) is responsible for full payment at the time of service. For unaccompanied minors, payment arrangements need to be made in ADVANCE and we must have a parent or guardians written permission prior to treatment of a minor.

____________**Initial**

3. Missed and Late Appointments:

- I agree to notify the office at least 2 business days in advance (48 Hours), if I am unable to keep any and all of my appointments. I also understand that if I do not give the required notice, I will be charged a fee of $200.00 for a missed Follow Up appointment, or a fee of $50.00 for a missed Carotid Artery Scan, Thyroid Ultrasound and/or VO2 test. In addition, if three (3) or more appointments are missed, The Institute for Hormonal Balance respectfully reserves the right to terminate our relationship with the patient.

____________**Initial**

4. You Must Realize However That:

- Your insurance is a contract between you, your employer and the insurance company. We are not a party in that contract.
- You are responsible for all charges that are denied/not covered by your insurance company for any advanced testing ordered by Dr. Lee or Rebecca Murray. Not all services are covered under insurances.

____________**Initial**

5. PATIENT RESPONSIBILITY AGREEMENT:

- I understand that the Institute for Hormonal Balance and Dr. Edwin Lee has opted out of accepting any and all health insurance, and therefore I am financially responsible for all services rendered.

____________**Initial**

I authorize release of any information concerning my health care and treatment provided for the purpose of evaluating and administering treatment. I hereby authorize payment of any missed appointments to be charged directly to the credit card I have provided

Credit Card #____ **Exp.**_______________**Sec.**________________

By signing below you consent to all the above conditions. **(please sign below)**

Signature ____ **Date**______________________

Patient Name ________________________________**DOB:**_____________**Date**____ __________

Patient Address ____

____

Phone Number ____

Drug Allergies

____

____

____

Medications with dosage

____

____

____

____

____

Past Medical History

____

____

____

____

Past Surgical History

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____

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____

Family History

Is there a family history of Diabetes?	Yes ___________	No ___________
Is there a family history of Heart Disease?	Yes ___________	No ___________
Is there a family history of Stroke?	Yes ___________	No ___________
Is there a family history of being Overweight?	Yes ___________	No ___________
Is there a family history of Cancer?	Yes ___________	No ___________
Is there a family history of Thyroid condition?	Yes ___________	No ___________
Is there a family history of High Blood Pressure?	Yes ___________	No ___________

Social History

Do you have children and if so how many? ___________________________________

Do you smoke or chew tobacco? ____

Do you drink alcohol? ____

IV drug use? ____

Do you use Recreational Drugs (pot, cocaine, etc)? _________________________

What is your marital status? ____

Have you had any of these symptoms within 3 months?

Fatigue	Yes ___________	No ___________
Mood Swings	Yes ___________	No ___________
Depression	Yes ___________	No ___________
Anxiety	Yes ___________	No ___________
Fibrocystic Breasts	Yes ___________	No ___________
Trouble Sleeping	Yes ___________	No ___________
Bloating	Yes ___________	No ___________
Memory Loss	Yes ___________	No ___________
Weight Gain	Yes ___________	No ___________
Slow Metabolism	Yes ___________	No ___________
Water retention	Yes ___________	No ___________
Hair Loss	Yes ___________	No ___________

Have you been suffering from these symptoms within 3 months?

Trouble getting up in the AM even when you go to bed early	Yes ___________	No ___________
Feeling overwhelmed	Yes ___________	No ___________
Can't bounce back from stress or illness	Yes ___________	No ___________
Crave salty and sweet snacks	Yes ___________	No ___________
Tired for no reason	Yes ___________	No ___________
More susceptible to flues and colds	Yes ___________	No ___________
Weight Gain especially around the middle	Yes ___________	No ___________

You feel better in a less stressful environment Yes ___________ No ___________

Are you experiencing? (somatopause)

Loss of muscle mass Yes ___________ No ___________
Thinning skin Yes ___________ No ___________
Decreased endurance Yes ___________ No ___________
Decreased reaction time Yes ___________ No ___________
Decreased bone density Yes ___________ No ___________
Trouble with vision Yes ___________ No ___________
Sagging skin Yes ___________ No ___________

For Men (the following 9 questions ONLY)

Loss of energy Yes ___________ No ___________
Low sex drive Yes ___________ No ___________
Inability to maintain an erection Yes ___________ No ___________
Loss of physical agility Yes ___________ No ___________
Hair Loss Yes ___________ No ___________
Reduced muscle strength Yes ___________ No ___________
Trouble concentrating Yes ___________ No ___________
Insomnia Yes ___________ No ___________
Nervousness Yes ___________ No ___________

Adrenal Health

Do you frequently have low body temperature? (<98 degrees F) Yes ___________ No ___________
Do you frequently get irritable? Yes ___________ No ___________
Do you have poor memory or concentration? Yes ___________ No ___________
Do you notice palpitations? Yes ___________ No ___________
Do you suffer from allergies or asthma? Yes ___________ No ___________
Do you bruise easily or find your wounds heal slowly? Yes ___________ No ___________
Do you get frequent chronic infections? Yes ___________ No ___________
Do you have dry thinning hair? Yes ___________ No ___________
Do you get headaches? Yes ___________ No ___________
Do you have unexplained hair loss? Yes ___________ No ___________
Do you skip meals? Yes ___________ No ___________
Do you exercise more than one time each week? Yes ___________ No ___________
Do you have thyroid problems? Yes ___________ No ___________
Is your energy good all day? Yes ___________ No ___________
Do you need caffeine in morning or after lunch? Yes ___________ No ___________
Are you emotionally overstressed? Yes ___________ No ___________
Do you get tenderness across your lower back? Yes ___________ No ___________
Do you suffer from depression or down moods? Yes ___________ No ___________
Do you have low blood pressure? Yes ___________ No ___________
Do you experience a “second wind” high energy at bedtime? Yes ___________ No ___________
Do you experience chronic or recurrent inflammation? Yes ___________ No ___________
Do you get light headed when sitting up or standing? Yes ___________ No ___________
Do you suffer from chronic pain? Yes ___________ No ___________
Do you suffer from low blood sugar / hypoglycemia? Yes ___________ No ___________
(i.e. headaches, sleepiness, mood swings if skipping meals)
Do you experience symptoms of PMS? Yes ___________ No ___________

(breast tenderness, abdominal cramping, heavy periods mood swings)
Are you menopausal or peri menopausal? Yes ___________ No ___________
(skipping periods, between 45-55 years old, hot flashes, vaginal dryness)
Do you suffer from insomnia? Yes ___________ No ___________
(If yes complete Insomnia section)

Insomnia

Do you experience difficulty falling asleep? Yes ___________ No ___________
Does your mind race when you are trying to go to sleep? Yes ___________ No ___________
Does it take you more than 20 minutes to fall asleep once lights off? Yes ___________ No ___________
Do you experience a "second wind" high energy at bedtime? Yes ___________ No ___________
Do you trouble staying asleep? Yes ___________ No ___________
Do you wake more than once a night? Yes ___________ No ___________
Do you have trouble going back to sleep once awakened? Yes ___________ No ___________
Do you frequently waken between 2-3am? Yes ___________ No ___________
Do experience restless legs when trying to sleep? Yes ___________ No ___________
Do you recall your dreams? Yes ___________ No ___________
Do you have vivid or disturbing nightmares? Yes ___________ No ___________
Do you sleep/nap during daylight hours? Yes ___________ No ___________
Do you feel groggy or sleepy when you awaken? Yes ___________ No ___________
Do you work "third shift" (work nights/sleep days)? Yes ___________ No ___________
Are you depressed when weather is cloudy or overcast? Yes ___________ No ___________
Are you taking any sleep, pills natural or prescription? Yes ___________ No ___________
Do you snore? Yes ___________ No ___________
Have you ever been diagnosed with sleep apnea? Yes ___________ No ___________
Do you use coffee, caffeine, or other stimulants/medications? Yes ___________ No ___________
Do you have children or pets that sleep in your room/bed? Yes ___________ No ___________
Do you exercise late in the day? Yes ___________ No ___________
Do you eat carbohydrate snacks before bed (cake, cookies, ice cream)? Yes ___________ No ___________
Do you eat nothing between dinner and bedtime? Yes ___________ No ___________
Do you drink alcohol at night? Yes ___________ No ___________
Do you have sinus problems/allergies/asthma that is worse at night? Yes ___________ No ___________
Does your sleep partner snore or keep you awake due to restlessness? Yes ___________ No ___________
Have you ever had a concussive injury (black out do to head trauma)? Yes ___________ No ___________
Is your insomnia related to your cycle? Yes ___________ No ___________
Are you menopausal or have you had a hysterectomy? Yes ___________ No ___________

Female Hormone Pre & Per Menopausal

Do you experience frequent or irregular periods/menstruation? Yes ___________ No ___________
Do you experience severe abdominal cramping with your period? Yes ___________ No ___________
Do you get breast tenderness around the time of your periods? Yes ___________ No ___________
Do you get moody or irritable during or just before your periods? Yes ___________ No ___________
Do you get heavy periods? Yes ___________ No ___________
Do you have uterine fibroids? Yes ___________ No ___________
Do you have trouble getting to sleep because your mind is racing? Yes ___________ No ___________
Have you had trouble getting pregnant or experienced a miscarriage? Yes ___________ No ___________
Do you get anxiety or panic attacks? Yes ___________ No ___________
Do you take or have you taken birth control pills in the last 2 years? Yes ___________ No ___________
Have you gone without a period for more than 3 months? Yes ___________ No ___________
Have you experienced depression or post partum depression? Yes ___________ No ___________
Do you get headaches/migraines around the time of your period? Yes ___________ No ___________
Do you get cravings for sugar, fat, salt, or chocolate? Yes ___________ No ___________

Do you experience pain during intercourse? Yes ___________ No ___________
Do you get bloating and water retention during/around your period? Yes ___________ No ___________
Do you take birth control pills, patches, injections, or hormone-types? Yes ___________ No ___________
Do you have a family history of breast, uterine, or ovarian cancer? Yes ___________ No ___________
Do you have endometriosis? Yes ___________ No ___________

Post Menopausal Women

Was your last menstrual period more than a year ago? Yes ___________ No ___________
Do you get "Hot Flashes"? Yes ___________ No ___________
Do you have severe sweating at night? Yes ___________ No ___________
Do you have vaginal dryness? Yes ___________ No ___________
Have you noticed vaginal thinning? Yes ___________ No ___________
Do you notice a reduced libido? Yes ___________ No ___________
Are you concerned for osteoporosis or hip/spinal fractures? Yes ___________ No ___________
Do you have trouble getting to sleep because your mind is racing? Yes ___________ No ___________
Do you get anxiety or panic attacks? Yes ___________ No ___________
Do you experience pain during intercourse? Yes ___________ No ___________
Do you take hormone replacement pills, patches, or injections? Yes ___________ No ___________
Do you have a family history of breast, uterine, or ovarian cancer? Yes ___________ No ___________
Have you had a hysterectomy? Yes ___________ No ___________

Authorization For Release and Use of Protected Health Information Under HIPAA

Patient's Name: ______________________________ **Soc. Sec. #:** ______________
Date of Birth: _________________________ **Telephone:** ______________________

1. The undersigned patient, named above, hereby executes this authorization in compliance with the Health Insurance Portability and Accountability Act, HIPAA, 45 CFR 164.104, requests that the following healthcare provider (including its agents, employees and associates) release his or her records:

Release Records From: ____
____
____

2. The above-named healthcare provider is requested to release the protected health information (PHI) that is described below to:

Release Records To:
Institute for Hormonal Balance, LLC
7009 Dr. Phillips Blvd. Ste. 150
Orlando, FL 32819

RECORDS ARE TO BE: ______Picked up _______ Mailed _______ Faxed: 407-352-2668

3. The protected health information released therein is specifically as follows:
_____ ALL RECORDS _________ X-Ray Films _____ Progress Notes _____ AIDS/HIV
_____ Operative Reports _________ER Records _____Discharge Summary _____ Psychiatric/ Psychological
_____ H & P _________ Drugs/Alcohol _____ Lab/Radiology Reports
_____ Other/Specific Date: ____

A. Purpose of Disclosure: _________ MEDICAL CARE ________ OTHER: : ______________________________
B. This authorization may be revoked at any time by a signed and properly dated written revocation sent to the specific health care provider being provided with the request, but this release cannot be revoked as to protected health information that had been previously released in reliance on this document.

C. I understand that I am under no obligation to sign this document and that my ability to obtain treatment will not depend in any way on whether I sign this authorization.
D. I understand that once the PHI is disclosed, it may be re-disclosed to individuals or organizations that are not subject to the federal privacy regulations. The Institute for Hormonal Balance, LLC cannot guarantee that the recipient of the information will not re-disclose this information.
E. A photocopy of this authorization shall be considered as effective and valid as the original and this authorization will expire (90) days after the date executed, unless earlier revoked.

____ ____________________
Patient's Signature/Legal Representative Signature (specify relationship) **Date**

____

Printed Name

Notice of Privacy Practices

* "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."
* We may use or disclose your protected health information for any purpose that is listed in this notice without your written authorization. We will not use or disclose your protected health information for any other reason without your written authorization. If you authorize us to use or disclose your protected health information, you have the right to revoke the authorization at any time."
* At The Institute for Hormonal Balance, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.
* The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.
* We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.
* We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
* We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.
* In an emergency, we may disclose your health information to a family member or another person responsible for your care.
* We may release some or all of your health information when required by law.
* You have the right to request restrictions on certain of our uses and disclosures of your protected health information for insurance payment or health care operations, disclosures made to persons involved in your care, and disclosures for disaster relief purposes. … Your request must describe in detail the restriction you are requesting. We will consider your request. But we are not required to agree. We cannot agree to restrict disclosures that are required by law."
* You have the right to request that we send your protected health information to an alternate address or by alternate means. [We] will try to accommodate reasonable requests in writing."
* You have the right to request that your protected health information in [our] medical record for you be amended. If you wish to request amendment of the information in your record, submit a written request to [us]. The request must include a reason to support the amendment. [We] may deny a request for amendment based upon any of the following circumstances:
    - The request is not in writing or does not include a supporting reason;
    - The information you want to change was not created by [us], and the originator of the information is available to make the amendment;
    - The information is not part of the designated medical record; or
    - The information in the record is accurate and complete.

If [we deny] your request for an amendment, we will give you a written explanation of the denial. If you still disagree with the explanation provided, you can submit your written disagreement to [us] as referenced above, or you can ask that your request for amendment

and explanation of the denial be included in any future disclosure of pertinent protected health information. If you submit a statement of disagreement, [we] may include a rebuttal statement addressing your statement of disagreement in the designated medical record."

You have the right to request an "accounting of disclosures." This is a list of certain disclosures made about you that were not related to the routine uses listed above. This list will not include disclosures prior to April 14, 2003, or those that you have specifically authorized. To request this list or accounting of disclosures, you must submit your request in writing to [us]. Your request must state a time period that may not be longer than six years and should indicate in what form you want the list (for example, on paper versus in an electronic file). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the estimated cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred."

* As we will need to contact you from time to time, we will use whatever address, telephone numbers or email address we have on file.
* You have the right to transfer copies of your health information to another practice.
* You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request or sign a records request form in regards to the information you are requesting.
* From time to time, [we] may change [our] practices concerning how we use or disclose protected health information, or how we will implement patient rights concerning their information. [We] reserve the right to change the terms of this notice and make new notice provisions effective for all protected health information maintained by [us]. [We] will follow the terms and conditions of the notice that is currently in effect."

* If you believe your privacy rights have been violated, you may file a complaint with [us] or with the Secretary of the Department of Health and Human Services. To file a complaint with [us], contact _________________________. All complaints must be submitted or verified in writing. You will not be penalized for filing a complaint

Acknowledgement

I have received a copy of The Institute for Hormonal Balance Notice of Privacy Practices.

Signed:___________________________Print Name:_______________________Date:___________