Patient Prescription Form

NAME:_____

Medication Name	Dosage	Usage (1 pill a day, 3 pills a day)

INTIMMEDICINE SPECIALISTS

PATIENT INFORMATION:	Appt. Date:	Appt. Time	Today's Date:	Date of Birth:

Patient Name:	Marital Status:	Phone Message: Yes Cell # Work #

Address:	Email:

Primary Physician: Name: Address: Phone: Fax:	Referring Physician: Name: Address: Phone: Fax:

PRIMARY INSURANCE INFORMATION

Insurance Company:	ID#	Group #
Address:	Phone #	
Policy Holder's Name:	Policy Holder's DOB:	Policy Holder Phone #
Policy Holder's Employer:	Relation to Ins:	Insurance Effective date:

SECONDARY INSURANCE INFORMATION

Insurance Company:	ID#	Group #
Address:	Phone #	
Policy Holder's Name:	Policy Holder's DOB:	Policy Holder Phone #
Policy Holder's Employer:	Relation to Ins:	Insurance Effective date:

Authorized Person to contact for billing or results

Name:	Phone:		Phone:

1. Financial Responsibility

I certify that the information I have provided regarding my insurance coverage is correct and authorize James A Simon MD PC. to verify insurance coverage and benefits allowed in accordance -with my insurance plan's policies

I authorize that payments be made directly to James A Simon MD for all medical insurance benefits which are payable under the terms of my insurance policy for the services provided.
I agree to pay any copayments, coinsurance, or deductible as required by my insurance plan for medical care provided to me or my dependent. I understand that I am responsible for knowing the terms and regulations of my insurance plan.
I agree to accept full responsibility for payment if my insurance coverage is not verified.

2. Release of Medical Information For Billing

I hereby authorize James A Simon MD PC to submit a claim to my insurance company, health .and welfare fund, Medicare or Medicaid for medical services provided to me or my dependent.

I also authorize James A Simon MD PC provide a copy of this release and a copy of medical records related to such services if requested by the payer. Further, I authorize James A Simon MD PC to release medical information to my consulting or primary care physician to assist with continuity of my health care. This release will expire one year from the date of my signature below unless I cancel this release in writing prior to that date.

3. Non-Covered Services

I agree to pay for medical services provided to me or my dependent which are not covered by the benefits in my insurance plan.

I Agree to the Above stated responsibility and consent

Name:	Signature:	Date:

James A. Simon, MD, PC - Rachel S. Rubin, MD
1850 M Street NW, Washington DC 20036

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATIN ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

This notice takes effect April 14, 2003 and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for the treatment, payment, and healthcare operations (TPO):
Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use or disclose your health information to obtain payment for services we provide for you.
Healthcare Operations: We may use or disclose your health information in connection with our healthcare operations. Computers are located throughout our practice. Schedules and the patient's proposed treatment are posted on the computer throughout our facility to achieve communication and high quality healthcare.
Your Authorization: In addition to our use of your information for TPO, you may give us written authorization to use your health information or to disclose it for other purposes. If you give us an authorization, you may revoke it in writing any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
To Your Family & Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
Persons Involved In Care: We may use or disclose health information to notify a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, than prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.
Marketing Health Related Services: We will not use your health information for marketing communications without your written authorization. We may forward a regular newsletter to our patients and prospective new patients which describe the various services available from our practice.
Required By Law: We may use or disclose your health information when we are required to do so by law. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, text message, letters or e-mail.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information.)
We will charge you a reasonable cost-based fee for expenses such as copies and staff time.
Disclosure Accounting: you have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than TPO, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.
Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information.
We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternate locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Questions & Complaints

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the top of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

PATIENT OR LEGAL GUARDIAN SIGNATURE

Signature

_____**Date**_____

IntimMedicine Specialists
1850 M Street, NW #450
Washington DC 20036

E-Prescription Consent

- **Formulary and benefit transactions**- Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions**- Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification**- Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.
-

By signing this consent form you are agreeing that James A. Simon, M.D., P.C. can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes. Understanding all the above, I herby provide informed consent to James A.Simon, M.D., P.C. To enroll me in the ePrescribe program. I have had the chance to ask questions and all my questions have been answered to my satisfaction.

SIGNATURE_____**DATE**_____

PRINT NAME_____

DATE OF BIRTH_____

E-MAIL:_____

NAME/ADDRESS/ PHONE NUMBER OF PHARMACY:

_____

Appointment Date: _____

IntimMedicine Specialists

Male Patient Questionnaire

Name: _____ Date of Birth: _____ Age: _____

Mailing Address: _____

Phone(s) (H) _____ (W) _____ (C) _____

Preferred phone: ☐Home ☐Work ☐Cell I prefer that messages be given by:

Referred by:_____

Address of Referring Physician(s): _____

_____

Occupation: _____

☐Single ☐In relationship ☐Co-habitating ☐Married/Domestic Partnership ☐Divorced/Separated ☐Other

Partner's Name _____

Allergies: _____

_____

Medications Currently Taking: _____

_____

_____

Reason for today's appointment: (Please check the appropriate statements below)

☐ Erectile dysfunction
☐ Pelvic Pain
☐ Ejaculatory dysfunction
☐ Orgasmic dysfunction
☐ Penile curvature
☐ Low Libido / Low Testosterone

Any other problems or concerns you wish to address today:_____

_____

_____

_____

Have you seen another physician for this problem? If so, what was their treatment?_____

_____

_____

Sexual History

YES

Are you sexually active? _____

Frequency of sexual intercourse per week_____

Do you have any sexual questions or concerns you would like to discuss? _____

Surgical History

Please describe any previous pelvic or abdominal surgery (appendectomy)

Type of Surgery Year Reason or Diagnosis Complications

List any other surgery:_____

Medical History

Do you have a history of:

- ☐ Ulcers or Stomach Problem
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Kidney Infections
- ☐ Bowel Problems
- ☐ Liver Problems
- ☐ Lung Disease
- ☐ Chronic Cough
- ☐ Visual Disturbances
- ☐ Rheumatic Fever
- ☐ Mental Health Issues
- ☐ Arthritis
- ☐ Gall Bladder Disease
- ☐ Stroke
- ☐ Kidney Stones
- ☐ Bladder Infections
- ☐ Hepatitis or Jaundice
- ☐ Lung Disease
- ☐ Sinus Problems
- ☐ Difficulty Swallowing
- ☐ Skin Problems, Acne
- ☐ Anorexia, Bulimia
- ☐ Easy Bruising
- ☐ Heart Murmur
- ☐ Loss of Urine
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Asthma
- ☐ Seizure Disorders
- ☐ Hearing Problems
- ☐ Cancer
- ☐ Other:_____

Please list treatments prescribed for items above:_____

Family History

YES

Indicate your ethnic background (i.e. African American, Mediterranean, Eastern European Jewish):_____

Is there a family medical history of cancer? _____
If so, what relative and what kind of cancer_____
_____

Is there a family medical history of diabetes? _____

Is there a family medical history of heart disease? _____

Is there a family medical history of mental health disorders? _____

Please list any other medical problems which seem to run in your family or are of concern to you:

_____
_____

Social History

YES

Have you had previous marriages? If so, how many?_____ _____

Do you smoke cigarettes now? If yes, how many packs/week?_____ _____
Have you smoked before and stopped? _____
How many years have you smoked in total?_____

Do you drink alcohol? If so, how many glasses/week?_____ _____

Do you use recreational drugs? _____
If so. specify_____

Have you ever worked with toxic chemicals? If so, specify_____

What do you do for exercise?_____

Over the past 4 weeks:

*Please check **one** box only*

☐ Q1	**How often were you able to get an erection during sexual activity?**	0 No sexual activity 1 Almost never or never 2 A few times (less than half the time) 3 Sometimes (about half the time) 4 Most times (more than half the time) 5 Almost always or always
☐ Q2	**When you had erections with sexual stimulation, how often were your erections hard enough for penetration?**	0 No sexual activity 1 Almost never or never 2 A few times (less than half the time) 3 Sometimes (about half the time) 4 Most times (more than half the time) 5 Almost always or always
☐ Q3	**When you attempted intercourse, how often were you able to penetrate (enter) your partner?**	0 Did not attempt intercourse 1 Almost never or never 2 A few times (less than half the time) 3 Sometimes (about half the time) 4 Most times (more than half the time) 5 Almost always or always
☐ Q4	**During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?**	0 Did not attempt intercourse 1 Almost never or never 2 A few times (less than half the time) 3 Sometimes (about half the time) 4 Most times (more than half the time) 5 Almost always or always
☐ Q5	**During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?**	0 Did not attempt intercourse 1 Extremely difficult 2 Very difficult 3 Difficult 4 Slightly difficult 5 Not difficult

☐ Q6	**How many times have you attempted sexual intercourse?**	0 No attempts 1 One to two attempts 2 Three to four attempts 3 Five to six attempts 4 Seven to ten attempts 5 Eleven or more attempts
☐ Q7	**When you attempted sexual intercourse, how often was it satisfactory for you?**	0 Did not attempt intercourse 1 Almost never or never 2 A few times (less than half the time) 3 Sometimes (about half the time) 4 Most times (more than half the time) 5 Almost always or always
☐ Q8	**How much have you enjoyed sexual intercourse?**	0 No intercourse 1 No enjoyment at all 2 Not very enjoyable 3 Fairly enjoyable 4 Highly enjoyable 5 Very highly enjoyable
☐ Q9	**When you had sexual stimulation or intercourse, how often did you ejaculate?**	0 No sexual stimulation or intercourse 1 Almost never or never 2 A few times (less than half the time) 3 Sometimes (about half the time) 4 Most times (more than half the time) 5 Almost always or always
☐ Q10	**When you had sexual stimulation or intercourse, how often did you have the feeling of orgasm or climax?**	1 Almost never or never 2 A few times (less than half the time) 3 Sometimes (about half the time) 4 Most times (more than half the time) 5 Almost always or always
☐ Q11	**How often have you felt sexual desire?**	1 Almost never or never 2 A few times (less than half the time) 3 Sometimes (about half the time) 4 Most times (more than half the time) 5 Almost always or always
☐ Q12	**How would you rate your level of sexual desire?**	1 Very low or none at all 2 Low 3 Moderate 4 High 5 Very high
☐ Q13	**How satisfied have you been with your overall sex life?**	1 Very dissatisfied 2 Moderately dissatisfied 3 Equally satisfied & dissatisfied 4 Moderately satisfied 5 Very satisfied
☐ Q14	**How satisfied have you been with your sexual relationship with your partner?**	1 Very dissatisfied 2 Moderately dissatisfied 3 Equally satisfied & dissatisfied 4 Moderately satisfied 5 Very satisfied
☐ Q15	**How do you rate your confidence that you could get and keep an erection?**	1 Very low 2 Low 3 Moderate 4 High 5 Very high

ADAMs questionnaire	YES
Do you have a decrease in libido (sex drive)?	
Do you have a lack of energy?	
Do you have a decrease in strength and/or endurance?	
Have you lost height?	
Have you noticed a decreased "enjoyment of life"	
Are you sad and/or grumpy?	
Are your erections less strong?	
Have you noticed a recent deterioration in your ability to play sports?	
Are you falling asleep after dinner?	
Has there been a recent deterioration in your work performance?	
Total	

If you Answer Yes to number 1 or 7 or if you answer Yes to more than 3 questions, you may have low Testosterone.