APPOINTMENT DATE: **ARRIVAL TIME:** **APPOINTMENT TIME:**

John B. Monaco, MD, FACOG, FAARFM, ABAARM
Nashville Hormone & Integrative Medicine Center, LLC
1909 Mallory Lane, Suite 108
Franklin, TN 37067
Phone: 615 964-5871 Fax 615 716-1040

PATIENT INFORMATION

Dr. Monaco and his staff are pleased that you have chosen us to care for your medical needs. This patient information packet will provide you with information about the practice which is essential for you to understand in order to insure that you receive efficient and high quality medical care. **Please read this entire information packet completely and carefully.**

In this packet you will receive information on:

- Office hours/Physician Appointments
- Urgent and emergency appointments
- Personal Health & Wellness Assessment **(required at initial visit)**
- What to expect at your appointment
- Obtaining lab and test results
- Telephone calls
- Prescriptions and prescription refills
- Financial counseling/insurance
- Concierge (VIP) medicine
- Nutritional Consults
- Agreement for Medical Services

OFFICE HOURS/PHYSICIAN APPOINTMENTS

Appointments to see Dr. Monaco are scheduled as follows:
Monday 6:20AM to 2:20PM
Tuesday 6:20AM to 2:20PM
Wednesday CLOSED
Thursday 6:20AM to 2:20PM
Friday 6:20AM to 11:00AM.

Appointments to see Christine Stengel, ACNP are scheduled as follows:
Monday 7:30AM to 11:30AM
Tuesday 7:30AM to 11:30AM
Wednesday 7:30AM to 11:30AM
Thursday 7:30AM to 11:30AM
Friday CLOSED

When calling for an appointment, please indicate to the receptionist whether you are a new patient, returning for a follow-up visit and who referred you.

We ask that you arrive at least 30 minutes prior to your appointment time to allow for parking and registration. A credit card is required at the time that you make your appointment. A charge of $100 will be

charged if you fail to show for your appointment. No appointment will be given without a credit card on file. If you arrive late, we may have to reschedule your appointment. A 48-hour cancellation notice is requested for new patient appointments. Cancellations made less than 24 hours may result in a $100 charge for a missed visit. Please bring your initial patient health survey filled out to your appointment. If you do not receive this at least 48 hours prior to your appointment, please call the office and we will e-mail one to you. If you arrive without your completed paperwork, your appointment may be rescheduled. As a courtesy to our patients, we ask for your cooperation. The arrival time for your appointment is not optional; this time is part of your appointment. We strive to run on time and to provide the best service possible.

A CREDIT CARD IS REQUIRED BY DR. MONACO TO BE HELD ON FILE FOR YOUR DURATION OF CARE.

URGENT & EMERGENCY APPOINTMENTS

If an emergency situation arrives, we will do our best to see you that same day or refer you to the closest emergency room. The E.R. physician will contact Dr. Monaco regarding your medical condition

PERSONAL HEALTH & WELLNESS ASSESSMENT

You will receive, either by email or regular mail, a Personal Health & Wellness Assessment which you will need to complete and bring with you to your initial consultation with Dr. Monaco. This assessment will provide our team with a complete personal medical, family and social history to which we refer to when needed. Accurate and complete information is critical for your health care. This provides a basis for which your personalized wellness program will be designed. We ask that you bring this **COMPLETED** form with you to your appointment. There will not be enough time to fill this out prior to your appointment and failure to have this information will require that we reschedule your appointment.

WHAT TO EXPECT AT YOUR FIRST APPOINTMENT

During your initial consultation, your Health & Wellness assessment will be reviewed and any additional pertinent medical information noted. Your weight and vital signs will be taken.
Your physician will perform a physical examination, review your assessment and the nurses' recommendations and recommend appropriate testing, medications, supplements, as deemed necessary. Follow-up appointments will be scheduled as appropriate for your particular circumstances. For all new patients and annual follow-up, a comprehensive series of lab tests may be ordered. Salivary testing is ordered as necessary to monitor hormone levels in patients using topical hormones.

During follow-up visits, all testing and laboratory results will be reviewed with you. You will receive a copy of all test results. A customized program which may include hormone restoration, medical, nutritional and nutraceutical (supplements) support will be given to you. You will be instructed on the reason for our recommendations, what to expect from your customized program, and how to take and use these medications, hormones and nutrients. You will be provided with a Medication & Supplement Sheet with our recommendations to which you can refer.

OBTAINING LAB AND TEST RESULTS

You will be given a copy of your test results at each follow-up visit.

TELEPHONE CALLS

Any calls after normal business hours will be addressed on the following business day. If you reach our voicemail, leave a DETAILED message, including your name, date of birth, phone number and a pharmacy number for prescription refills. Emergency calls will be addressed immediately. Non-emergency calls will be returned by the end of the day. If you are calling for a prescription refill, leave a message including the name of the medication needed and a prescription number, if available.

PRESCRIPTIONS

Prescriptions will be phoned into a pharmacy **ONLY** during office hours. Controlled substances will **NEVER** be phoned into a pharmacy after hours or on weekends. Please allow at least 72 for hormone prescriptions to be called in and compounded so that you do not experience an interruption in therapy. If you use a mail order pharmacy, please tell our staff at the time of your visit so that a short-term prescription can be written for you to use at a local pharmacy until your mail order arrives. All prescriptions are now generated from our electronic medical record system.

FINANCIAL COUNSELING AND INSURANCE

Co-pays are due at the time of each visit. Patients are responsible for all charges not covered by their insurance plans. We appreciate your timely payment of all medical charges. Salivary test kits are purchased at each visit which allows us to pass on a savings to the patient. Payments may be made via Cash, Check, Visa, MasterCard or American Express at the registration desk upon completion of your visit. Returned checks will incur a $25 charge to cover bank costs. Returned checks may also cause loss of the option to pay by check. Refunds for salivary kits may only be given when the kit is returned to the office.

CONCIERGE MEDICINE

Concierge medicine membership is an alternate way of receiving additional services to your medical care from my office. The benefits of being a concierge member include extended consultation time with Dr. Monaco, preferred appointment scheduling, usually within 24 hours, unlimited access with no additional office fees or costs. I am pleased to offer these additional services and I believe that should you choose this option, you will be most pleased. Membership is on a yearly basis and is based on the initial visit. The membership fee may be deductible from your Health Savings Account or Cafeteria Plan. To request a membership form, quote for current membership fees or if you would like to consult with someone about the benefits of Concierge Medicine, please ask to speak with the Administrator, Lesa McPherson Monaco, BS, RN.

NUTRITIONAL CONSULTS

A large component of achieving hormone balance and wellness involves lifestyle and lifestyle modifications. The cornerstone of wellness and lifestyle is nutrition. Part of your customized wellness program may involve a structured lifestyle and nutrition program. We are pleased to have Danielle Gilbert, Dietician available for our patients. She will be able to help you individualize a nutrition and exercise plan to assist you in reaching your health goals. Appointments can be made for a consult with Danielle by our receptionist.

NEW PATIENT GUIDELINES

Thank you for choosing our practice to provide your hormonal and integrative medicine care. We promise to do our very best to address your needs.

We make every attempt to see our patients promptly at their appointment time. If we are running late it is usually because a patient has arrived late for their appointment or has not arrived in advance of their appointment.

In order to avoid delays and long wait times and to be considerate of everyone involved we ask for your cooperation with the following:

NEW PATIENTS: **Please arrive 30 minutes before** your scheduled appointment. You must have your completed initial patient package with you. Please make sure it is filled out completely and accurately. Please call us in advance if you have not received your new patient package or need help locating the document on our website. Failure to do so may result in your appointment being cancelled and rescheduled. You will need to plan for traffic delays and allow time for parking.

RETURNING PATIENTS: **Please arrive 15 minutes prior** to your appointment to allow time for registration. By doing so, we can usually have you into the exam room promptly.

Many of our patients have other appointments for testing. We strive to conclude their visit to make sure that they can complete these tests in a timely fashion.

We hope to avoid having to cancel and reschedule an appointment but in some cases, this may be unavoidable. Your cooperation in this matter is greatly appreciated by all.

If you need to make changes to your appointment please give the office a 48 hour notice or this may result in a fee. You may be charged a fee for same day cancellations of appointment or failure to show for an appointment.

John B. Monaco, MD, FACOG, FAARFM

Please sign below that you understand everything you have read in this packet and that you agree to abide by the patient terms with this office.

Signature: _____Date: _____

AGREEMENT FOR MEDICAL SERVICES & COMPLIANCE

Achieving wellness and hormone balance requires proper training and skill and the full cooperation of the patient. A personalized wellness program will be designed for you which includes, but is not limited to, laboratory testing, saliva testing, other diagnostic testing and imaging, lifestyle evaluation and recommendations, nutritional counseling, prescription medications, compounded medications including bioidentical hormones, thyroid hormone and adrenal support and high quality nutraceuticals supplements. In order to achieve the best possible results,

reduce the risk of developing chronic disease and reduce the occurrence of adverse events, it is imperative that you follow this protocol exactly without deviation, modification or substitution. **Changing the dosage or recommended schedule of prescription medications may result in adverse events. Modifying or substituting nutritional products for lesser quality products obtained at discount stores or on the internet may negatively affect your results and have, in my experience, resulted in unsatisfactory results, lack of results and lost time.** I recommend only the highest quality nutrients that are produced in the highest caliber facilities which assures that the nutrient contains and does what it is designed to do. Absorption of nutrients is the key and many cheaper products are either poorly absorbed or not absorbed at all. If you have an issue with any medication or nutrient, you must call to discuss these issues with my staff. **Any change or deviation made without our knowledge or consent may result in adverse outcomes for which we cannot be responsible.** Your cooperation in this matter is necessary and greatly appreciated.

I agree _____ Date _____

Patient Signature

NASHVILLE HORMONE AND INTEGRATIVE MEDICINE CENTER, LLC

FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

Private insurance companies and Medicare often dictate what test can be ordered/covered and this coverage cannot be accurately predicted. Reimbursement to physicians is at an all time low and deductibles are increasing.

_____I understand that I have the right to refuse medical treatment at any time for any reason and such refusal may impact the ability to diagnose and treat me.

_____I understand that I am responsible for the cost of my medical care and for the claims not paid by my insurance company including my insurance deductibles and copays.

_____I understand that I cannot request Nashville Hormone & Integrative Medicine Center, LLC, its' physicians, employees or agents to dismiss, waive or reduce any charges not reimbursed by my insurance company regardless of the reason.

Proper hormone evaluation may require several different types of testing, in addition to blood testing. These tests may not be covered by your insurance or they may be partially reimbursable by your insurance company. Some test may be partially covered and require a co-pay. While you have the right to refuse any testing, such refusal may make it difficult or impossible to accurately diagnose and resolve your hormonal issues. The commonly used tests are listed below. Any one of these tests may be offered to you to address your specific and individual needs.

You have the right to refuse any and all tests that are recommended for you.

Saliva testing: $85-225 (Payable at visit)

Iodine testing; $75 (Payable at visit)

Stool testing: $169 (Co-pay payable to lab) depending on Ins.

Food Allergy $0 - $400 recommended

Estrogen Metabolism: $144 (Co-pay to lab)

24 hr urine Estrogen Metabolism: $176 (Co-pay to lab)

28-Day Saliva Testing: Copay to lab

Serum: $20- $4000 Depending on tests

_____ _____

Signature Date

Patient Name: _____ Physician: _____

Date of Birth: _____ Todays Date: _____

Instructions: Please circle Y for those that apply to YOU and/or YOUR FAMILY – BOTH MOM AND DADS SIDE OF FAMILY. Include any of the below family members:

Yourself Mother Father Brother Sister Children Paternal Uncle/Aunt Maternal Uncle/Aunt
Niece/Nephew Maternal Grandmother/Grandfather Paternal Grandmother/Grandfather First Cousin

This is to determine if you are at risk of a gene mutation that may cause cancer in you or family members.

	Diagnoses	YOU	Family Member	Moms/Dads Side	Age at
Y N	Breast Cancer	____	_____	_____	_____
Y N	Breast Cancer in both Breasts or Breast Cancer twice in same person	____	_____	_____	_____
Y N	Male Breast Cancer	____	_____	_____	_____
Y N	Triple Negative Breast Cancer Under 65, (ER-, PR-, Her2-)	____	_____	_____	_____
Y N	Pancreatic Cancer	____	_____	_____	_____
Y N	Ovarian Cancer	____	_____	_____	_____
Y N	Colon/Colorectal Cancer	____	_____	_____	_____
Y N	Uterine/Endometrial	____	_____	_____	_____
Y N	Stomach/Bladder	____	_____	_____	_____
Y N	Other Cancers (Renal Pelvis, Brain, Biliary Tract, Small Bowel)	____	_____	_____	_____

Y N Ashkenazi Jewish Ancestry ____ _____ _____ _____

Y N Have you or any family member ever been tested for BRAC of Lynch Syndrome?
If yes, please explain:
_____

_____
Signature Date

Nashville Hormone & Integrative Medicine Center, LLC
Health & Wellness Assessment
John B. Monaco, MD, FACOG. FAARFM
Christine Stengel, ACNP

Date: _____ Social Security Number: _____-_____-_____

Patient Information

Name: _____ Date of Birth: _____

Address: _____
_____

Home Phone: ( ) _____-_____ Work Phone: ( )_____-_____

Cell Phone: ( ) _____-_____ Email: _____

Marital status: _____ Age: _____ Gender: M F

Who referred you: _____

Patient Employer Information

Employer Name: _____

Employer Address: _____

Spouse or Parent Information:

Name: _____ Birth Date: _____

Employer: _____ Phone Number: _____

Employer Address: _____

Emergency Information-List nearest living relative

In case of an emergency we may contact:

_____

Relationship to patient: _____ Phone number:

_____

Primary Care Physician: _____ Referring Physician:

_____

Personal Information

Birthplace: _____ Education:

_____

Occupation: _____ Children:

_____

Religious Preference: _____

DrugAllergies:_____

_____

_____

Food Allergies:_____

Other Allergies: _____

Chief Complaint(s)/Symptoms (Reason(s) for Visit: List in order of importance/severity

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

Are you seeing other physicians: _____

List names, address, phone numbers and specific problems for which they are treating you.

_____

_____

_____

Persons With Whom Results May Be Released:

_____

HORMONES

The First day of your last Menstrual Cycle: _____

If Menopausal, How Long: _____

What Hormones/if any have you used in the past:

_____

Check the following Symptoms that you are experiencing:

- Hot Flashes
- Night Sweats
- Vaginal Dryness
- Low Libido
- Problems obtaining an orgasm
- Concentration
- Memory
- Anxiety
- Depression

ADRENALS

How many hours do you sleep each night: _____

Interrupted: Y N How many times do you wake each night: _____

Do you dream during sleep: Y N Sometimes: /7 nights

Do you recall your dreams: Y N Sometimes: /7 nights

Are you normally tired during the day? Yes

_____No_____

When is your best energy in the day? Morning _____ Noon _____ Evening

_____

Do you ever have a Mid-Afternoon Slump? Yes _____ No _____

Do you get a second wind in the early afternoon? Yes _____ No_____

If so, for how long? 30 Mins _____ 1 Hour _____ 1-2 Hours _____ 3+ Hours
_____

THYROID

Check the following Symptoms that you are experiencing:

- Loss of Outer Eyebrow
- Cold Hands and Feet
- Cold Body Temperature
- Dry Brittle Nails
- Dry Skin
- Dry Hair
- Thinning Hair
- Voice Changes (Hoarseness/Raspy)
- Puffy Eyes/Dark Circles
- Constipation

- Weight Gain (cannot loose despite diet and exercise)
- Generally tired in the AM and energy increases as the day progresses

Do you have any food sensitivities or allergies (Gluten, Dairy etc.):

_____

Do you have any Auto Immune Disorders, please list them if yes:

_____

____

Please list all medications/supplements and dosages: (Please use additional paper if needed)

1._____

____

2._____

____

3._____

____

4._____

____

5._____

____

6._____

____

7._____

____

8._____

____

9._____

____

10._____

____

11.

_____

_

12.

_____

_

Please list all previous Medical History/Diagnoses:

_____

_____

_____

_____

_____

_____

Please list all Medication Allergies/Intolerances/Sensitivities:

_____

_____

_____

OBSTETRICAL/GYN HISTORY

A full Menstrual Cycle is the first day of your cycle to the first day of your next cycle.
Ex. Menstruating starts on January 1st, then starts next on February 1st = 31 Day Cycle

How many days does your cycle last: _____ Days

When was your last Pap smear: _____ Normal? _____

When was your last Mammogram: _____ Normal? _____

Please indicate the number of the following:

Pregnancies _____ Full Term _____ Miscarriages _____ Terminations

_____

Vaginal Deliveries _____ Cesarean _____ Total Living Children

_____

Menarche (onset of menstrual cycle):

Age at onset of periods: _____ Duration of Menstruation: _____ Days

Regular? (28-30 days): _____ Flow: Heavy Light Normal

Please list all surgeries and the date you have had them:

1._____ Date:

_____

2._____ Date:

_____

3._____ Date:

_____

4._____ Date:

_____

5._____ Date:

_____

Please list all Hospitalizations and dates:

1._____ Date:

_____

2._____ Date:

_____

3._____ Date:

_____

4._____ Date:

_____

5._____ Date:

_____

Family History:

Father- Alive or Deceased Age: _____ Medical Problems:

_____

_____

____

Mother- Alive or Deceased Age: _____ Medical Problems:

_____

_____

____

Any other significant family history:

_____

_____

_____

_____

Do you drink caffeine? _____ If so, how many cups per day:

_____

Do you exercise? _____ If so, how many times per week:

_____

Did you have a drink containing alcohol in the past year? _____ How often?

_____

Please check one:

Are you: Current Smoker _____ Former Smoker _____ Never Smoker _____

If former smoker, how long ago did you quit? _____

If current smoker, how many cigarettes do you smoke in a typical day? _____

Do you use smokeless tobacco: _____ If yes, how often? _____

Please don't forget to bring this packet completely filled out with your ID, Insurance Cards, and Credit/Debit Card to keep on file.

Thank You.

Name: **DOB:** **MRN:**

DEBIT/CREDIT CARD PAYMENT AND USE AGREEMENT

The mission of Nashville Hormone and Integrative Medicine Center, LLC (hereafter NHIMC) is to provide quality healthcare to our valued patients. We remain committed to maintaining the most efficient billing process for our patients, including the filing of all insurance claims prior to requests for payment. In return, we require that you provide an approved credit or debit card for payment on the patient balance. Once you receive a statement notifying you that an insurance provider has paid their portion of the services provided, you will have a thirty (30) day notification period to make payment arrangements. Your credit/debit card will only be used to pay the patient balance remaining (including deductibles and co-insurance) if you have not made other payments arrangements. Please contact NHIMC's billing representative at 615-964-5871, if you have any questions concerning this process. We have taken the appropriate steps to secure the safety of your personal and financial information. Your credit/debit card information will be secured in the same manner as protected health information (PHI) and NHIMC will not disclose any personal or financial information to any other people or companies.

PLEASE REVIEW AND SIGN BELOW:

I understand that I have been requested to supply a credit/debit card at the time of registration for the above patient.
Upon notification of receipt of insurance payment, any outstanding balance remaining on the above patient's account will be automatically applied to my credit/debit card after a thirty (30) day notification period, unless I have made other payment arrangements prior to that date.
NHIMC will not be responsible for any card issues, penalties or fees associated with applying my remaining balance to my credit/debit card.
I agree to pay the remaining patient balance for the above patient according to my cardholder agreement.

CARDHOLDER'S SIGNATURE **DATE**

NOTICE OF ACKNOWLEDGEMENT
I acknowledge that I have received/reviewed the NHIMC Notice of Privacy Practices

(Patient or Personal Representative Signature) **(Relationship to Patient)**

FINANCIALS AND BILLING

I understand that I am responsible for charges incurred during the course of my treatment by NHIMC .

I will, also, be responsible for any REFERRAL or PRECERTIFICATION authorization required by my insurance company. In the event I fail to obtain the proper REFERRAL or PRECERTIFICATION authorization for Specialty Services, I agree that I am responsible for the charges incurred during my visit.

I authorize NHIMC to release to the Social Security Administration, its intermediaries, or other insurance carriers any and all information needed to secure payment. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits be issued to the physician.

This authorization is valid for any claim and/or billing services rendered to me by NHIMC. Should assistance be required in the collection of any unpaid balance, I agree to pay all collection costs and /or reasonable attorney fees.

I authorize NHIMC to release medical records by fax or mail to a referring physician when deemed necessary.

Signature **Printed Name**
Date

Nashville Hormone & Integrative Medicine CTR, LLC
John B. Monaco, MD, FACOG, FAARFM, ABAARM
1909 Mallory Lane, Suite 108
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P: 615-964-5871
F: 615-716-1040

Notice of Agreement for Lab Appointments

By signing below, you are agreeing to complete all labs, saliva testing, etc. within 48 hours of your scheduled lab appointment. If these tests are not fully completed within this time frame, your results may not be available in time for your appointment. This will result in rescheduling your appointment and a rescheduling fee of $50.00. If you call and make arrangements with the office to reschedule your appointment, you will not be charged.

Patient Signature

Date