New Patient Guidelines

John "Jack" B. Monaco, MD, FACOG, FAARFM, ABAARM

Nashville Hormone & Integrative Medicine Center, LLC

1909 Mallory Lane, Suite 108, Franklin, TN 37067

Office: 615 964-5871 - Fax: 615 716-1040

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 ensure 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 6:20 AM to 2:20 PM
Wednesday Lab Appointments Only
Thursday 6:20 AM to 2:20 PM
Friday 6:20AM to 11:00AM.

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.

Online forms are automatically submitted to our office. If you choose to print and fill out your form home, it is required that you have it submitted at least 24 hours before your appointment or we will have to reschedule the appointment.

We ask that you arrive at least 30 minutes prior to your appointment time to allow for parking and registration.

Patients arriving after the scheduled time will likely need to reschedule the visit and may be subject to the $100.00 cancellation fee.

All no-shows will be a $100 no-show fee.

A VALID DEBIT OR CREDIT CARD MUST BE SUBMITTED TO SET UP AN APPOINTMENT AND WILL BE KEPT ON FILE FOR ALL PATIENTS.

Any patient not on Medicare or Tricare must pay a $100 deposit to schedule as a new patient.

NHIMC RETAINS THE RIGHT TO USE THE SUBMITTED CARD AS THE PRIMARY METHOD OF PAYMENT UNLESS OTHERWISE SPECIFIED.

We will not charge the card without permission from the patient.

A 48-hour cancellation notice is requested for new patient appointments.

Cancellations or schedule changes require a 24-hour notice.

In the event you miss the appointment without proper notification you will be subject to pay the $100.00 fee. By completing this form you are agreeing to these conditions. The $100.00 fee for cancellations and/or no-shows will be the responsibility of the patient to pay.

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 submit this COMPLETED form before 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.

When calling for a refill, we must have pharmacy info, medication info, and dosage.

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 hours 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 (if applicable)

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 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 a loss of the option to pay by check. Refunds for salivary kits may only be given when the kit is returned to the office. There is a 3-4% service fee applied to in-office credit/debit card transactions, including HSA cards. Cash or check is preferred.

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 call

the office and a receptionist can assist you.

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.

New Patient Guidelines

Thank you for choosing our practice to provide your hormonal and integrative medical 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 submitted before your appointment. 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 canceled and/or 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.

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.

Appointment Date

Signature **Date**

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 assure 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 nutrients, 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 (sign below)

Today's Date

Financial Responsibility Acknowledgement

Private insurance companies and Medicare when accepted can 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.

Please check each box below after reading.

- [ ] **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, including (if applicable) my insurance deductibles and/or 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. (if applicable)**

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 tests 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.

New Patient: Self: $550,

Initial Follow-Up: Self: $275

20 Min Follow-Up: $95

40 Min Follow-Up: $150

Reestablished: Self: $425

Nurse Visit: Self: $75

Phone Consult: 20 min- Self: $150

40 min- Self: $195

60 min- Self: $250

Saliva Kits:

EPT: $90

Cortisol: $150

HP3: $250

Iodine: $85

Heavy Metal: $150

Signature

Date

Patient Information

Patient Information

Patient First Name

Patient Last Name

Date of Birth

Social Security Number

Age

Email Address

Work Phone

Home Phone

Address

City

State

Zip

Martial Status

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Who referred you?

Patient Employer Information

Employer Name

Address **City** **State**

Zip

Spouse or Parent Information

☐ **If not available, please check this box**

Name **Date of Birth**

Employer **Phone Number**

Emergency Information

In case of emergency we may contact **Relationship to patient**

Primary Care Physician **Referring Physican**

☐ **If not available, please check this box.**

Personal Information

Birthplace

Education

Occupation

Children

Religious Preference

Drug Allergies

Food Allergies

Other Allergies

Chief Complaint(s) / Symptoms / Reason(s) for Visit

Are you seeing other physicians?

List names, address, phone number & specific problems for which you are being treated

Person(s) with whom may be released

Medical History

Hormones

☐ **If not applicable, please check this box.**

The first day of your last menstrual cycle

If menopausal, for how long?

What hormones have you used in the past?

Check the following symptoms that you are experiencing:

☐ Hot Flashes ☐ Night Sweats ☐ Vaginal Dryness ☐ Low Libido ☐ Problem Obtaining Orgasm ☐ Concentration ☐ Memory

☐ Anxiety ☐ Depression ☐ None

Adrenals

How many hours do you sleep each night?

Interrupted?

Yes | No

How many times do you wake each night?

What typically wakes you?

Do you wake tired, rested or other?

Do you dream during sleep?

Yes | No | Sometimes

Do you recall your dreams?

Yes | No | Sometimes

Are you normally tired during the day?

Yes | No | Sometimes

When is your best energy in the day?

Morning | Noon | Evening

Do you ever have a mid-afternoon slump?

Yes | No | Sometimes

Do you get a second wind in the early afternoon?

Yes | No | Sometimes

If so, for how long?

30 minutes | 1 hour | 1-2 hours | 3+ hours

Thyroid

Check the following symptoms if you are experiencing them in any way

☐ Loss of outer eyebrow ☐ Cold hands & feet ☐ Cold body temperatures ☐ Dry brittle nails ☐ Dry skin ☐ Dry hair ☐ Thinning Hair ☐ Voice changes (hoarseness/raspy) ☐ Constipation ☐ Weight gain (cannot loose despite diet and exercise) ☐ Generally tired in the AM and energy increases as the day progresses ☐ None

Do you have any food sensitivities or allergies

Do you have any auto-immune disorders? Please list them if so.

Please list all medications/supplements and dosages

Please list all previous medical history/diagnoses

Pleases 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

☐ **If this is not applicable, please check this box.**

What date did your last period start?

What is the duration of your cycle? How many days does it typically last?

What is your typical flow?

Light | Normal | Heavy

Do you have any spotting between cycles?

Yes | No | Occasionally

When was your last pap smear?

Normal?

Yes | No

When was your last mammogram?

Normal?

Yes | No

Indicate the number of the following

Pregnancies **Full Term** **Miscarriages** **Terminations**

Vaginal Deliveries **Cesarean** **Total Living Children**

Age at onset of periods

Duration of Menstruating

Typical flow when menstruating

Light | Normal | Heavy

Please list all surgeries, including cosmetic, and the date you had them

Please list all hospitalizations and dates

Lifestyle & Family History

Lifestyle

Do you drink caffeine?

Yes | No | Sometimes

If so, how many cups per day?

Do you exercise?

Yes | No | Sometimes

If so, how many days per week?

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

Yes | No

How often?

Are you...

Current smoker | Former smoker | Never a 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?

Yes | No | Sometimes

If yes, how often?

Family History

Is your father alive or deceased?

Alive | Deceased

Age (currently or when deceased)

Medical Problems

Is your mother alive or deceased?

Alive | Deceased

Age (currently or when deceased)

Medical Problems

Any other significant history?

Risk Assessment for Hereditary Cancers

Instructions: Please choose 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.

	Yes or No?	**You**	**Family Member**
Breast Cancer	Yes / No		
Moms/Dads Side		**Age at Diagnoses**	

	Yes or No?	**You**	**Family Member**
Breast Cancer in both Breast or twice in same person	Yes / No		
Moms/Dads Side		**Age at Diagnoses**	

	Yes or No?	**You**	**Family Member**
Male Breast Cancer	Yes / No		
Moms/Dads Side		**Age at Diagnoses**	

	Yes or No?	**You**	**Family Member**
Triple Negative Breast Cancer Under 65 (ER-, PR-, Her2-)	Yes / No		
Moms/Dads Side		**Age at Diagnoses**	

	Yes or No?	**You**	**Family Member**
Pancreatic Cancer	Yes / No		
Moms/Dads Side		**Age at Diagnoses**	

	Yes or No?	**You**	**Family Member**
Ovarian Cancer	Yes / No		
Moms/Dads Side		**Age at Diagnoses**	

	Yes or No?	**You**	**Family Member**
Colon/Colorectal Cancer	Yes / No		
Moms/Dads Side		**Age at Diagnoses**	

	Yes or No?	**You**	**Family Member**
Uterine/Endometrial	Yes / No		
Moms/Dads Side		**Age at Diagnoses**	

	Yes or No?	You	Family Member
Stomach/Bladder	Yes No		

Moms/Dads Side

Age at Diagnoses

	Yes or No?	You	Family Member
Other Cancers (Renal, pelvis, brain, biliary tract, small bowel)	Yes No		

Moms/Dads Side

Age at Diagnoses

	Yes or No?	You	Family Member
Ashkenazi Jewish Ancestry	Yes No		

Moms/Dads Side

Age at Diagnoses

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

Financial Agreement

Debit/Credit Card Payment and Use Agreement

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 (if applicable) 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 (if applicable) 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 payment 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 (if applicable), 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.

Card Photo Upload

Signature

Date

Notice of Acknowledgement

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

Signature

Date

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 (if applicable). 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 (if applicable) 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 (if applicable) 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

Date

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.

Signature

Date