ALLENDE CENTRE

NATIONAL BOARD OF OSTEOPATHIC MEDICINE
AMERICAN BOARD OF FAMILY MEDICINE
AMERICAN BOARD OF ANTI-AGING AND REGENERATIVE MEDICINE

INTEGRATED MEDICINE EVALUATION

IF YOU ARE A PATIENT THAT REQUIRES ANY TYPE OF HORMONE TREATMENT AND/OR MEDICATIONS, YOUR INSURANCE WILL NOT BE BILLED FOR THE OFFICE VISITS. DR. ALLENDE CONDUCTS THESE TREATMENT AS A CONCIERGE SERVICE AND YOU WILL HAVE TO PAY OUT OF POCKET FOR ALL DOCTOR VISITS.

NO EXCEPTIONS

WE ARE NOT RESPONSIBLE FOR ANY INSURANCE COMPANY CHARGES WHEN IT COMES TO YOUR LABS. WE RECOMMEND HIGHLY THAT YOU USE OUR IN-HOUSE LAB WHICH IS A FIXED PRICE AT ALL TIMES. IF YOU MUST USE SALIVA OR URINARY HORMONE METABOLITE TESTING, YOU WILL KNOW THE CHARGE PRIOR TO PROCESSING WITH TESTING. IN THIS WAY WE CAN AVOID ANY MISUNDERSTANDINGS ABOUT INSURANCE COVERING ANY LAB TESTING.

6234 N. First St
Fresno CA 93710
Phone: (559) 435-5727 Fax: (559) 435-5503

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INTEGRATED MEDICINE EVALUATION

INITIAL EVALUATION FEE: $900

Overview

Our mission is to provide our patients with the most effective and state of the art Functional and Anti-Aging medical services in California.

Utilizing the latest scientific technologies, our primary goal is to promote wellness by focusing on the early detection and prevention of chronic and age related diseases.

Our varied therapies include Bio-Identical Hormone balancing as well as a physician guided weight management and facial aesthetics.

Bio-Identical Hormone Replacement Therapy or BHRT as more commonly known is simply the balancing and optimization of major hormone levels which include adrenal, thyroid, sexual and growth hormones.

By replacing the depleted hormone levels with Bio-Identical Hormones (those possessing the exact molecular structure as the ones your body naturally produces) the outcome is truly amazing. Benefits include the decrease of age related diseases such as: heart disease, diabetes, increase in body fat, increased energy level and overall zest for life, the improvement of cognitive thinking, including sharper memory, and much higher level of sexual desire and performance.

***This evaluation is a concierge service and your insurance will not be billed for it. The non-refundable $900 fee paid for the treatment is only for the first office visit and the follow-up visit to establish the treatment plan regarding hormones and nutrition supplementation for the first ninety (90) days of treatment. Any other problems that are not regarding hormones and are discussed with Dr. at the time, must be billed to the insurance carrier if the patient has one for private health, or if no insurance is available the patient must pay cash for the visit. After the first ninety days and every ninety days after, there will be a repeat of a blood panel and a follow-up visit. At each follow-up visit there is a fee of $300 that will be due to continue the therapy. If you're unable to attend the 90 day follow-up appointment, a phone consultation is available; however lab work and fees will still apply on a quarterly basis. Any further questions requiring a phone consultation within the 90 days will be done at an additional fee of $75 per phone call. The yearly total of the Integrated Medicine Therapy is $1200-$1800 and DOES NOT INCLUDE ANY MEDICATION. We can make the medication available to you for purchase if your insurance does not cover the medication. You may request a prescription to take to a pharmacy of your choice. Our office will initiate any prior authorization request from your insurance company for any of the medications ordered for your regimen. We also can do specialized blood testing here in the office at the price of $500, if you have not met your deductible or do not have any health insurance to cover any testing needed.

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Name (last, first, MI)			Social Security No.		Birth Date
Age	Sex	Marital Status M / S / D	Home Phone ( )		Work Phone ( )
Home Address (street, city, state and zip code)			Cell Phone ( )		
			Email Address		
Employer			Job Title		
Emergency Contact (Name)		Contact (Phone)			Who referred you?
Personal Physician (Name and Address) Office Phone:					Preferred Pharmacy Name/Phone

History

This section is for the purpose of learning more about your health history. Please read and answer all of the following questions to the best of your knowledge.

Reason for Consultation

What health concern and symptoms brings you to the clinic? _____

Patient Name: _____ Date of Birth: _____

What would you most like to achieve with this health consultation? _____

_____

_____

_____

_____

_____

_____

_____

Are you currently under the care of a physician or health professional for a medical/health condition? ○ Yes ○ No **If yes, please list condition(s):** _____

_____

_____

_____

_____

Past Medical History

Please check any medical conditions or health problems that you currently have or have had in the past?

Headaches (Migraines, other)	○ yes ○ no	Heart Disease	○ yes ○ no
Seizures Disorder	○ yes ○ no	Chest Pain	○ yes ○ no
Recurrent sinus infections	○ yes ○ no	Irregular Heart Beat	○ yes ○ no
Seasonal allergies	○ yes ○ no	High Blood Pressure	○ yes ○ no
Psychiatric or Emotional Illness	○ yes ○ no	Blood Clotting problems	○ yes ○ no
Depression	○ yes ○ no	Bleeding disorder	○ yes ○ no
Anxiety or excessive stress	○ yes ○ no	Stroke/vascular disease	○ yes ○ no
Asthma	○ yes ○ no	Constipation/diarrhea	○ yes ○ no
Chronic bronchitis	○ yes ○ no	Hepatitis/Liver disease	○ yes ○ no
Lung or breathing problems	○ yes ○ no	Kidney disease	○ yes ○ no
Chronic Indigestion	○ yes ○ no	Menstrual disorders	○ yes ○ no
Stomach Ulcers	○ yes ○ no	Reproductive problems	○ yes ○ no
Intestinal Disease	○ yes ○ no	Prostate problems	○ yes ○ no
Skin problems/dermatitis	○ yes ○ no	Sexual/Libido problems	○ yes ○ no
Back Pain or Sciatica	○ yes ○ no	Tendonitis	○ yes ○ no
Herniated Disc	○ yes ○ no	Chronic pain problems	○ yes ○ no
Neck pain	○ yes ○ no	Shoulder problems	○ yes ○ no
Chronic Muscle or Joint Pain	○ yes ○ no	Osteoarthritis	○ yes ○ no
Carpal Tunnel Syndrome	○ yes ○ no	Rheumatoid Arthritis	○ yes ○ no
Fibromyalgia	○ yes ○ no	Artificial joint/implants	○ yes ○ no
Diabetes	○ yes ○ no	Cancer	○ yes ○ no
Thyroid disease	○ yes ○ no	Psoriasis or eczema	○ yes ○ no
Osteoporosis/Osteopenia	○ yes ○ no		

List any additional health problems not listed above: _____

_____

_____

_____

Patient Name: _____ Date of Birth: _____

List any surgeries/operations you have had, and when: _____

_____

_____

_____

List any medications you are currently taking (or have taken in the recent past)

Medication Name	Date Started	Date Stopped	Dosage *(amt/# daily)*

(If any additional medications please attached a separate page list the above info)

Nutritional supplements, vitamins, herbs, homeopathic remedies taken: _____

_____

_____

_____

_____

_____

_____

_____

_____

Medication Allergies: _____

_____

_____

Environmental/Food Allergies: _____

_____

_____

Preventive Tests:	*Month/Year of last test*	*Test Results (if known)*
Cholesterol	_____	_____
Bone density	_____	_____
Colonoscopy	_____	_____
Exercise stress test	_____	_____

Patient Name: _____ Date of Birth: _____

Family History *(Write the relationship of the relative(s) with the disease on the adjacent lines)*

Heart Disease	O yes O no	_____
High Blood Pressure	O yes O no	_____
Diabetes	O yes O no	_____
Arthritis	O yes O no	_____
Skin disorders	O yes O no	_____
Breast Cancer	O yes O no	_____
Uterine/Ovarian Cancer	O yes O no	_____
Prostate Cancer	O yes O no	_____
Colon Cancer	O yes O no	_____
Other Cancer	O yes O no	_____

List any other disease/condition in the family and relationship? _____

_____

_____

WOMEN

ARE YOU PREGNANT? O yes O no First day of last menstrual cycle _____

Date of last pap/pelvic/breast exam _____ Results: O normal O abnormal

Date of last mammogram _____ Results: O normal O abnormal

Do you perform monthly self breast exams O yes O no

Are you currently taking or have you in the past taken hormones or oral contraceptives O yes O no

If yes, please list all hormones and oral contraceptives you have taken and when _____

_____

_____

_____

_____

_____

Patient Name: _____ Date of Birth: _____

Have you ever had any problems or concerns about taking hormone replacement therapy?

O yes O no

If yes please list problem: _____

_____

How many pregnancies have you had? _____ How many children? _____

Have you had a hysterectomy? O yes O no If yes, were your ovaries removed? O yes O no

Have you had any menstrual irregularities? O yes O no *(if yes explain)* _____

_____

_____

_____

Has your abdominal girth and weight been increasing? O yes O no

MEN

Date of last prostate exam: _____

Are you concerned with loss of muscle mass, tone, or strength? O yes O no

Have you had problems with urination *(decreased stream, frequent night urination)* O yes O no

Do you perform periodic testicular self examination? O yes O no

Has your abdominal girth and weight been increasing? O yes O no

Social History and Personal Health Habits

- **General** ***(Check all that apply)***

  My health is O *excellent* O *good* O *fair* O *poor.*

  My physical fitness is O *excellent* O *good* O *fair* O *poor*

  O I am under a lot of stress O I am fatigued all the time O I am having difficulty dealing with stress O I practice meditation or other relaxation techniques O I am often sad and blue

- **Dietary Habits**

  O No special diet habits O Avoids red meat O Minimizes fat O Minimizes Carbs O Vegetarian

  O Emphasize fruits, grains and vegetables O I try to eat a healthy diet

  O I do not eat dairy/cheese O I commonly eat at fast food restaurants

  I commonly consume: O Coffee O Regular soft drinks O Diet soda O Candy/chocolate O Chips/crackers

- **Exercise Habits**

  O No special exercise habits O I routinely exercise ____hr(s) ____X/week

  O Aerobic exercise (jog/walk/treadmill) O Lift weights O Swim

  O Stretch/Yoga/Tai Chi/Chi Gong

  Other_____

Patient Name: _____ Date of Birth: _____

- **Tobacco Use**
  - O I never smoked cigarettes or chewed tobacco
  - O I now smoke _____ packs of cigarettes per day. I have smoked for _____years
  - O I quit smoking in _____(mo/yr). I smoked _____packs/day for _____ years
  - O I smoke cigars/pipe
- **Alcohol Use**
  - O I never drink alcohol O I drink occasionally or socially
  - O I regularly drink: O 1-2 drinks/day O more than 2 drinks/day O more than 4 drinks/day
- **Hobbies/Sports/Recreation**

  List routine hobbies/sports/recreational activities: _____

_____

_____

_____ _____

Patient Signature **Date**

A 24 hour notice of cancellation is required. If your cancellation is less than 24 hours or you do not show for your appointment a rescheduling fee will apply before for your next appointment. This is for the consideration of our patients that are waiting for a sooner appointment and allows us the necessary time to contact them with the sooner appointment availability. We thank you for understanding regarding this policy that has proven to be very successful in meeting our patient's medical needs.

Practitioner comments on above: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PROGESTERONE

SIGNS & SYMPTOMS	NEVER				ALWAYS
1. My breasts are large.	0	1	2	3	4
2. My close friends complain I'm nervous and agitated.	0	1	2	3	4
3. I feel anxious.	0	1	2	3	4
4. I sleep lightly and restlessly.	0	1	2	3	4
The following questions are for women who have not yet reached menopause, and menopausal women who are taking hormone replacement therapy (estrogen or estrogen and progesterone).					
5. My breasts are swollen and tender or painful before my period…	0	1	2	3	4
6. My lower belly is swollen…	0	1	2	3	4
7. I'm irritable and aggressive…	0	1	2	3	4
8. I lose my self-control…	0	1	2	3	4
9. I have heavy periods…	0	1	2	3	4
10. My periods are painful.	0	1	2	3	4

Add up your Overall Score _____:
Post-menopausal women not treated with hormone replacement therapy (estrogen or estrogen and progesterone): 4 or less: Satisfactory level. Between 5 and 8: Possible Progesterone deficiency. 9 or more: Probable Progesterone deficiency.
Menstrual women and menopausal women taking hormone replacement therapy (estrogen or estrogen and progesterone): 10 or less: Satisfactory level. Between 11 and 20: Possible Progesterone deficiency. 21 or more: Probable Progesterone deficiency.

TESTOSTERONE

SIGNS & SYMPTOMS (Men and Women)	NEVER				ALWAYS
1. My face has gotten slack and more wrinkled.	0	1	2	3	4
2. I've lost muscle tone.	0	1	2	3	4
3. My belly tends to get fat.	0	1	2	3	4
4. I'm constantly tired.	0	1	2	3	4
5. I feel like making love less often than I used to.	0	1	2	3	4
SIGNS & SYMPTOMS (Men Only)					
6. My breasts are getting fatty.	0	1	2	3	4
7. I feel less self-confidant and more hesitant.	0	1	2	3	4
8. My sexual performance is poorer than it used to be.	0	1	2	3	4
9. I have hot flashes and sweats.	0	1	2	3	4
10. I tire easily with physical activity.	0	1	2	3	4

Add up your Overall Score _____
Score for Women: 5 or less: Satisfactory level. Between 6 and 10: Possible Testosterone deficiency. 11 or more: Probable Testosterone deficiency.
Score for Men: 10 or less: Satisfactory level. Between 11 and 20: Possible Testosterone deficiency. 21 or more: Probable Testosterone deficiency.

GROWTH HORMONE

SIGNS & SYMPTOMS (Men and Women)	NEVER				ALWAYS
1. My hair is thinning.	0	1	2	3	4
2. My cheeks sag.	0	1	2	3	4
3. My gums are receding.	0	1	2	3	4
4. My abdomen is flabby / I've got a "spare tire".	0	1	2	3	4
5. My muscles are slack.	0	1	2	3	4
6. My skin is thin and / or dry.	0	1	2	3	4
7. It's hard to recover after physical activity.	0	1	2	3	4
8. I feel exhausted.	0	1	2	3	4
9. I don't like the world. I tend to isolate myself.	0	1	2	3	4
10. I feel continuously anxious and worried.	0	1	2	3	4

Add up your Overall Score _____:
Overall total is 10 or less is satisfactory level. Between 11-20: Possible Growth Hormone deficiency. 21 or more: Probable Growth Hormone deficiency.

DHEA

SIGNS & SYMPTOMS (Men and Women)	NEVER				ALWAYS
1. My hair is dry.	0	1	2	3	4
2. My skin and eyes are dry.	0	1	2	3	4
3. My muscles are flabby.	0	1	2	3	4
4. My belly is getting fat.	0	1	2	3	4
5. I don't have much hair under my arm.	0	1	2	3	4
6. I don't have much hair in the pubic area. (0 = plenty of hair / 4 = hairless)	0	1	2	3	4
7. I don't have much fatty tissue in the pubic area. (flat "mound of Venus" in women). (0 = padded / 4 = flat)	0	1	2	3	4
8. My body doesn't have much of a special scent during sexual arousal.	0	1	2	3	4
9. I can't tolerate noise.	0	1	2	3	4
10. My libido is low.	0	1	2	3	4

Add up your Overall Score _____:
Overall total is 10 or less is satisfactory level. Between 11-20: Possible DHEA deficiency. 21 or more: Probable DHEA deficiency.

Do You have a Hormone Deficiency? *Continued*

THYROID

SIGNS & SYMPTOMS	NEVER				ALWAYS
1. I'm sensitive to cold.	0	1	2	3	4
2. My hands and feet are always cold.	0	1	2	3	4
3. In the morning my face is puffy and my eyelids are swollen.	0	1	2	3	4
4. I put on weight easily.	0	1	2	3	4
5. I have dry skin.	0	1	2	3	4
6. I have trouble getting up in the morning.	0	1	2	3	4
7. I feel more tired at rest than when I am active.	0	1	2	3	4
8. I am constipated.	0	1	2	3	4
9. My joints are stiff in the morning.	0	1	2	3	4
10. I feel like I'm living in slow motion.	0	1	2	3	4

Add up your Overall Score _____
Overall total is 10 or less is satisfactory level. Between 11-20: Possible Thyroid Hormone deficiency. 21 or more: Probable Thyroid Hormone deficiency.

ESTROGEN

SIGNS & SYMPTOMS	NEVER				ALWAYS
1. I am losing hair on top of my head.	0	1	2	3	4
2. I am getting thin, vertical wrinkles above my lips.	0	1	2	3	4
3. My breasts are droopy.	0	1	2	3	4
4. My face is too hairy.	0	1	2	3	4
5. I have hot flashes.	0	1	2	3	4
6. I feel tired constantly.	0	1	2	3	4
7. I am depressed.	0	1	2	3	4
8. My menstrual flow is heavy. (0=moderate / 1-3=low / 4=none)	0	1	2	3	4
9. Women with periods: My cycles are irregular, too short (<27 days), or too long (>31 days).	0	1	2	3	4
10. Women without periods: I do not feel like making love anymore.	0	1	2	3	4

Add up your Overall Score _____
Overall total of 10 or less is satisfactory level. Between 11-20: Possible Estrogen deficiency. 21 or more: Probable Estrogen deficiency.

Circle the answers to the ailments and discuss them with your physician.

ENERGY

1. Do you have a hard time getting up in the morning? YES NO
2. Do you always feel tired or tired in the afternoon? YES NO

SEX

1. Do you lack sexual desire? YES NO
2. Does your penis or clitoris seem less sensitive? YES NO
3. Are your erections not firm enough? YES NO
4. Have you lost your attraction toward your partner? YES NO
5. Do you lack vaginal lubrication? YES NO

SLEEP

1. Do you sleep poorly? YES NO
2. Do you rarely dream? YES NO

MEMORY

1. Do you suffer from short- or long-term memory loss? YES NO
2. Do you have trouble concentrating? YES NO

SKIN & HAIR

1. Wrinkles on your face along the nose, smile lines, forehead creases? YES NO
2. Do you have little wrinkles around the eyes and crows feet? YES NO
3. Do you have age spots? YES NO
4. Do you have dry, thin skin? YES NO
5. Are you losing your hair or is it turning gray? YES NO

WEIGHT CONTROL

1. Is your abdomen too plump? Is it distended? YES NO
2. Women: Are your breast too large? Do they get larger before you period? YES NO
3. Are your buttocks and thighs too well padded? YES NO
4. Are you pear shaped? YES NO

STRESS & MOOD

1. Do you suffer from constant fatigue? YES NO
2. Do you have high blood pressure? YES NO
3. Are you anxious, nervous, or irritable? YES NO
4. Do small things set you off? YES NO
5. Are you depressed? YES NO

JOINTS & BONES

1. Do you have arthritis? YES NO
2. Do you have osteoarthritus in the hip? YES NO
3. Do you have fibromyalgia (sharp shoulder pain)? YES NO
4. Have you lost muscle mass, tone, and strength? YES NO
5. Do you have bone loss of the spine, hips, hands, wrist, and feet? YES NO

Low Testosterone Questionnaire

ADAM Questionnaire (Androgen Deficiency in the Aging Male)

If you are concerned that your testosterone level is low, this set of ten simple questions is a good place to start. You can save a copy of this form to your personal computer by clicking on the file menu on the top left of the page and then selecting "save as" or "save a copy".

	Answer YES or NO to each of the following questions:	Yes	No
1.	Do you have a decrease in libido (sex drive)?		
2.	Do you have a lack of energy?		
3.	Do you have a decrease in strength and/or endurance?		
4.	Have you lost height?		
5.	Have you noticed a decreased "enjoyment of life?"		
6.	Are you sad and/or grumpy?		
7.	Are your erections less strong?		
8.	Have you noticed a recent deterioration in your ability to play sports?		
9.	Are you falling asleep after dinner?		
10.	Has there been a recent deterioration in your work performance?		

If you answered YES to questions 1 or 7 or any 3 other questions, you may be experiencing androgen deficiency (low testosterone level). A simple saliva test done in the privacy of your home can help you determine your free testosterone level. To order a home-saliva testosterone test click the link below.

***Adapted from Morley, et al. Validation of a screening questionnaire for androgen deficiency in aging males. Metabolism. 2000;49(9):1239-1242*

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WEIGHT LOSS AND/OR IN COMBINATION WITH BIOIDENTICAL HORMONE REPLACEMENT EVALUATION CONSENT FORM

The patients are informed that any type of Bioidentical Hormone Replacement Evaluation and/or the use of any medications that increase the metabolism to stimulate weight loss in the form of appetite suppression carry an inherent risk. These inherent risks, as it pertains to the Bioidentical Hormone Replacement Therapy may expose an underlying condition in a patient such as a "malignancy or cancer". The hormones by themselves carry a small risk of tumor or malignancy but because they are bio-identical to human hormones these types of benign or malignant growths are much more treatable than traditional synthetic, animal based or plant based hormones related malignancies. This is more likely in female patients than male patients. (The risk of this is minimal and there is a screening process that the patients go through in the lab work up and the questionnaires that ask about disclosure regarding any history of malignancy from themselves or any blood related family. All medications that you, the patient is taking must be listed in the history profile to make a full disclosure to the Physician and/or Medical Personnel and thus assisting in the proper recommendation for you, the patient. All patients must sign a full disclosure form which is part of this informed consent form. You note and are made aware of many possible risk factors associated with the Bioidentical Hormone Replacement Therapy and that it may cause an underlying medical condition to be exposed and eventually diagnosed. These medications and/or hormones, if taken in the appropriate and recommended manner, according to Physician recommendation, should minimize or reduce risk of side effects or other hormones treatment related complications. The use of all hormones may have side effects and these side effects will always be discussed with you the patient and myself the physician prior to initiating treatment. This treatment will be based on goals of treatment established with you the patient and myself the physician.

As it pertains to the Weight Loss medications typically used, these are appetite suppressants that can cause an increase in heart rate and/or elevated blood pressure. Therefore, underlying existing medical conditions need to be made aware of to the Physician. Such as coronary artery disease, high blood pressure or any other heart conditions. All patients need to disclose all medical conditions and any medications being taken as these medications may be contraindicated or may put you the patient at risk for an adverse treatment response, in particular symptoms of high blood pressure, coronary artery disease, diabetes, peripheral vascular disease, carotid artery disease, history of a myocardial infarction (which means a heart attack) and any history of stroke as well.

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These particular conditions would preclude and not make the patient eligible to take the appetite suppressive sympathomimetic medications and an alternative can be offered.

As it pertains to the Bioidentical Hormone Replacement Therapy, we use Bioidentical Hormones that are synthetically produced for patient use. It may be in the form of an injection and/or topical form. We do also implant slow release pellets. Most Oral forms are not used at this particular office because they are not as biologically available and the absorption is erratic. The metabolism of these hormones make them poorly absorbed or they are altered in the digestive tract to a metabolite that may be harmful to you. There is an inherent risk associated with any type of injection at the injection site such as bleeding or the possibility of infection. These are readily treatable conditions usually without sequelae and there is a very low risk of this occurring if sterile technique has taken place at the injection site as instructed when first starting injection therapy. This is always discussed with you the patient on the first visit if you are determined to be a candidate for Bioidentical Hormone Replacement Therapy.

At any time if the patient is to notice an altered physiologic process of their body and/or they start to experience symptoms that are not normally present such as difficulty initiating urine stream and/or maintain a urine stream or have excessive perspiration (sweating) and/or significant decrease in appetite or significant weight loss which would be defined as more that 10% in 1 month time span, without specifically attempting weight loss. This is an indication to discontinue medications at once and be evaluated by the Physician (myself) and/or my Nurse Practitioner or Physician Assistant.

All patients are subject to blood testing every 3-6 months and initially it is every 12 weeks followed by every 3-6 months as well as a physical examination at least once a year unless an abnormality in physical or bodily function presents itself as stated above. In such case, the patient is to return to the clinic immediately.

Any patient not following the treatment process as defined above will be discontinued off all medications. This is a letter of informed consent for all patients to sign at the time of the initial evaluation that they understand the process, what the process is and they understand the risks associated with the medications being used.

Thank you.

Diego Allende, D.O.

Patient Signature: _____ Date: _____

Physician: _____ Date: _____

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HIPAA Consent Form

PATIENT'S NAME: _____

The health Insurance portability and Accountability Act of 1996 provides safeguards to protect your privacy. These safeguards include restriction on who may see or be notified of your protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you or your family with treatment. HIPPA provides certain rights and protections to you as a patient. We must balance these needs with our goal of providing you with quality service and care. For this reason, our practice has adopted the following policies:

1. Patient information will be kept conditional except as is necessary to provide treatment or to ensure that all administrative matters related to your care are handled appropriately. Patient files may be stored in open file racks, but will not contain any coding, which identifies a patient's condition or information, which is not already a matter of public record. The normal course of providing care means that such records may be left in administrative areas such as the front office, Doctor's office, etc. The patient agrees to the normal procedures utilized within the facility for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of the office to remind patients of their appointments. This may be done by telephoning patients or by any other means convenient for the practice.
3. The practice utilizes a number of vendors in order to contact business. These vendors may have access to PHI, but agree to abide by the confidentiality rules of HIPPA.
4. The patient understands and agrees to inspections of the office and the review of documents, which may include PHI by government agencies or insurance companies in the normal performance of their duties.
5. The patient agrees to bring any concerns or complaints regarding privacy to the attention of the Doctor or Office Manager.
6. Your confidential information will not be used for purposes of advertising or marketing of products, goods or services. Such prohibition does not include treatment/product samples or goods of normal value.
7. The practice agrees to provide the patient with access to their records in accordance with State Law.
8. The practice may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

I, _____ do herby agree to the terms set forth above and any subsequent changes in the office policy. I understand that this consent shall remain in force so long as I am a patient of this practice.

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Patient Discloser of Information

Patient Name: _____ Date: _____

All patient health history stated to Physician in Bioidentical Hormonal Therapy Treatment workup said, all to be true. There are no signs and history of any abnormalities, which include, difficulty urination, bleeding from the rectum, Carcinoma and/or malignancies (of any kind of Cancer), deformities of any parts of the body, including lumps, or changes on the body, and for **(woman)** no possibility of being pregnant, and/or becoming pregnant while on therapy.

As with any treatment there are possible side effects that will be discussed at the initial consultation. By signing this agreement Dr. Allende will not be held responsible for such said conditions. While in this Therapy Treatment with Dr. Allende if any of the following should occur **immediately** follow up with your Primary Care Doctor. At that time Dr. Allende will discontinue the Hormonal Therapy Treatment. This Protocol is clearly stating for the patient to understand all risk and complications and/or possible side effects.

Patient Signature: _____

Physicians Signature: _____

6234 N. First St
Fresno CA 93710
Phone: (559) 435-5727 Fax: (559) 435-5503

ALLENDE CENTRE
NATIONAL BOARD OF OSTEOPATHIC MEDICINE
AMERICAN BOARD OF FAMILY MEDICINE
AMERICAN BOARD OF ANTI-AGING AND REGENERATIVE MEDICINE

Patient Request for Non-Disclosure of Medical Records

I, _____, hereby assert to my constitutional right to privacy and expressly forbid my physician and anyone acting under his or her control, from releasing any of my medical records to a third party without my express consent.

In particular, I decline to consent to the release of my medical records for the purpose of entry into a computer database which may be accessed by third parties outside of the offices or hospitals utilized by my physician.

Signature: _____ Date: _____

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