_____ _____

Print Name DOB

Authorization to Obtain Blood:

I authorize the medical staff of T Off Men's Health to obtain a blood sample for the purpose of any blood levels we see medically necessary.

_____ _____

Patient Signature Date

If the following section is not filled out and signed, our office will only release information to the patient or guardian.

Authorization to Release Information to Someone Other than Myself:

I authorize T Off Men's Health to release medical, appointment, and/or financial information over the telephone and/or to release copies of my medical records to the following person, I also authorize the doctor's office listed below to release all medical records to T Off men's Health:

Name of Authorized Person/Spouse _____ DOB or SS _____

Relationship to Patient _____ Phone Number _____

Name of Doctor _____ Phone Number _____

_____ _____

Patient Signature Date

Patient Information:

Last Name _____ First Name _____ M Initial _____

DOB _____ SS _____How did you hear about us? _____

Address _____

City _____ ST _____ Zip _____ Cell _____

Home Phone _____ Work Phone _____

Employer _____ Emp City/ST/Zip _____

Email Address _____

Pharmacy Name_____ **Pharmacy Number**_____

Pharmacy Address/Location_____

May we send you a reminder the day before your appointment via text? (Circle one) Yes No
(We will not send you any other text messages.)

Emergency Contact Name _____ Phone Number _____

Relationship to Patient _____

_____ _____
Patient Signature Date

Patient Financial Policy

We are committed to providing you with the best possible care. In order to achieve this, we want you to understand our financial policy. Below we have provided detailed information pertaining to this policy. All or only some of the policy may apply to you and your current situation.

- We are providers for many managed care plans. We will file claims for those plans we participate in, and will require you to pay your copay/deductible/coinsurance at the time of the visit. You will need to complete all necessary forms to file for insurance carrier payments.
- Full payments for services are due at the time services are rendered for all self-paying patients (patients with either no insurance, or we are out of network with insurance). We accept cash, checks, Visa, MasterCard, Discover, and American Express.
- We are not providers for Medicaid or Medicare and will only accept Medicaid and Medicare patients as self-pay. We will not file any claims to Medicaid or Medicare as primary or secondary insurance.
- Assignment of Benefits – I hereby assign all medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier to issue payment directly to T Off Men's Health for medical services rendered to me regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance, including any labs sent to an independent lab.
- Authorization to Release Information – I hereby authorize T Off Men's Health to release any information necessary to process any claim. I certify that this information is true and correct to the best of my knowledge. I authorize payment of medical benefits to be made on my behalf to T Off Men's Health. I hereby authorize photocopies of forms to be recognized as valid as the original.

_____ _____

Patient Signature Date

_____ _____

Print Patient Name DOB

Receipt of Notice of Privacy Practices Acknowledgement Form

I have received and reviewed the Privacy Practice Notice for T Off Men's Health. I understand the situations in which this practice may need to release my medical records or information pertaining to my medical records.

I understand that T Off Men's Health will properly maintain my records, and take all precautions necessary to protect my privacy.

_____ _____

Patient Signature Date

_____ _____

Print Name DOB