RevitaLife
MEDICAL & SPA

# Patient Intake Form

## Patient Information

Name: _____ Date of Birth: _____

Gender: _____ Marital Status: _____

Primary Address: _____

City: _____ State: _____ Zip Code: _____

**Please check where we may leave a message for you.**

☐ Home Phone: _____ ☐ Cell Phone: _____

☐ Work Phone: _____ Email: _____

Employer: _____ Occupation: _____

**May we discuss your care with anyone else?** ☐ Yes ☐ No
**If yes, please include the person's name, phone number and relationship to you.**

| Name | Phone | Relationship |
|---|---|---|
| | | |

Referred by: _____

## Emergency Contact Information

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

## Pharmacy Information

Pharmacy: _____ Phone: _____

## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE AND FINANCIAL POLICY

**I acknowledge that I have received a copy of RevitaLife's Privacy Notice and Financial Policy.**

_____ _____
**Signature of Patient or Guardian** **Date**

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What brings you to RevitaLife?

_____

_____

## Lifestyle Information

Tobacco use (chew, smoke, or snuff): ☐ Yes ☐ No

How often? _____ How much? _____

**Alcohol use:**

How many drinks currently per week? ☐ None ☐ 1-3 ☐ 4-6 ☐ >10

**Caffeine use (tea, coffee, or soda):**

How many drinks currently per week? ☐ None ☐ 1-3 ☐ 4-6 ☐ >10

**Exercise:**

Current Exercise Activity ☐ Stretching ☐ Cardio/Aerobics ☐ Strength ☐ Yoga/Pilates ☐ Sports

**Exercise:**

How often do you exercise each week? ☐ None ☐ 1-2 ☐ 3-4 ☐ 5-7

**Sleep:**

Average number of hours you sleep per night ☐ >10 ☐ 8-10 ☐ 6-8 ☐ <6

**Sleep:**

How would you rate your overall sleep health? ☐ Good ☐ Fair ☐ Poor

**Sleep:**

Do you snore or stop breathing when sleeping? ☐ Yes ☐ No

**Weight/Height:**

What is your approximate height? _____

What is your current weight? _____

What is your goal weight? _____

What is your highest weight? _____

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**Hormone Therapy/Weight Loss: Please check if you have had these symptoms in the past 6 months:**

- ☐ Decreased sense of well being
- ☐ Decreased muscle strength
- ☐ Decreased memory
- ☐ Sadness, depression
- ☐ Mood swings
- ☐ Decreased sex-drive
- ☐ Decreased energy
- ☐ Thinning or hair loss
- ☐ Night sweats
- ☐ Prolonged exercise healing
- ☐ Difficulty sleeping
- ☐ Increased fat deposits
- ☐ Heat or cold intolerance
- ☐ Hot flashes

## Past and Current History

Are you currently seeing other physicians? ☐ Yes ☐ No

If yes, please list names below:

_____

_____

_____

_____

| **Allergies:** Please list all allergies and what reaction occurred (if any) | |
|---|---|
| | Reaction |
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

| **Herbal/Supplements:** Please list all Herbal/Supplements you are currently taking | |
|---|---|
| | Reason for use |
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| 6. | |
| 7. | |

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| **Medication:** Please list all prescription medications you are currently taking | | | |
|---|---|---|---|
| | Dose | Frequency | Reason for Use |
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |
| 9. | | | |
| 10. | | | |

| **Medical condition:** Please list all medical conditions you have or had in the past |
|---|
| 1. |
| 2. |
| 3. |
| 4. |
| 5. |

| **Surgeries:** Please list all previous surgeries | |
|---|---|
| Date | Surgery |
| | |
| | |
| | |
| | |
| | |

**Preventative/Diagnostic Testing:** Please check the box if you have had any of the following

☐ Colonoscopy: Date _____

☐ Bone Density: Date _____

☐ Cardiac Stress Test: Date _____

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**MEN'S Preventative Testing:** Please check box if yes and provide the date

☐ PSA: Date _____

☐ Prostate exam (rectal) Date _____

**WOMEN'S Preventative Testing:** Please check box if yes and provide the date

☐ Mammogram Date _____

☐ PAP Test Date _____

## Family History

| Please list any illness the following members of your family have/had | Age at death |
|---|---|
| Mother: | |
| Father: | |
| Siblings: | |
| Children: | |

## Women Only

Age at last period: _____ Date of last period: _____

Are you periods regular? ☐ Yes ☐ No

Any PMS symptoms? ☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No

Are you trying to get pregnant? ☐ Yes ☐ No

Uterine ablation ☐ Yes ☐ No

Uterine or IUD? ☐ Yes ☐ No

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## RevitaLife Advanced Beneficiary Notice (ABN)

Patient Name: _____ Date of Birth: _____

This notice is to inform you that your insurance company may not pay for all of the services that you receive in the course of your treatment at our clinic. This may include, but is not limited to:

- Genova Testing
- Additional Blood Testing
- Pellets
- Injections
- Medical Weight Loss Programs
- Food
- B12 Medication
- Cosmetic Services
- Supplements
- Skin Care
- Office Visits
- EKG
- IV Nutrition

Each insurance's out of network benefits are unique as to what services you could be reimbursed for.
Treatments that are not reimbursable by any insurance to you will be your full responsibility at the time of service.
By signing this notice, you agree to take financial responsibility for the costs of supplies or services provides.

_____ _____

**Patient Signature** **Date Signed**

* A copy of this notice will be kept in your patient file. You may request a copy of this notice at any time.

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# Patient Intake Form

## Patient Consent to Treatment

By reading and signing this document the undersigned patient (or authorized representative) consent to, agree and authorize RevitaLife to perform treatments, examinations, prescribe medications, medical services and diagnostic procedures as ordered and approved by the physician and RevitaLife staff and discussed with me. I understand that I may have other conditions that will continue to be cared for by my primary care physician. I acknowledge and consent to the following:

1) I am at least 18 years of age and I have provided a full and accurate medical history to RevitaLife. I acknowledge that the medical history I provided to RevitaLife is true and accurate and I am aware that any Information I did not provide prior to treatment cannot hold RevitaLife personnel treating me responsible for loss or liability that may result due to my failure to provide such information.
2) I understand and agree that as a condition to my receiving treatment with RevitaLife I will continue to visit my primary care physician, regardless of the extensive follow ups specific to the diagnosis discussed by my RevitaLife physician or treating personnel.
3) RevitaLife physician, personnel, and healthcare professionals cannot guarantee any specific results of any examination, treatment, procedure, or medical care. I release RevitaLife, its providers, and healthcare professionals from any and all liability for any accident or injury that is not directly caused by the negligence of RevitaLife or its employees. I further understand that the overall diagnosis and treatment may involve risks or injuries. As a result, I understand and agree to hold RevitaLife personnel and RevitaLife physicians harmless and free of liability if I should encounter an adverse event related to the treatment or medications prescribed that could result in my incurring additional medical costs.
4) During the course of my care and treatment, I understand that various types of examinations, tests, and diagnostic or treatment procedures may be necessary. These procedures may be performed by physicians, nurses, technicians, or other healthcare professionals. While routinely performed without incident, there may be material risks associated with these procedures; I will ask my healthcare professional or physician to provide me with additional information. I understand RevitaLife personnel and or physicians may ask me to sign additional informed consent documents relating to specific procedures and treatments.
5) I agree not to give, sell, or allow anyone other than myself to use any medication provided to me through my treatment with RevitaLife.
6) I understand that RevitaLife has contracts with pharmacies for compound medications.
7) I understand that hormones and the ancillary use of medications while taking hormones or undergoing treatment for a specific diagnosis observed by a RevitaLife physician can result in the unknown side effects which may not become evident until a future date. As a result, I agree to take my medications exactly in the manner prescribed to me by my RevitaLife physician and agree to release RevitaLife, or RevitaLife personnel and RevitaLife physicians from any liability for any misuse, unintended use, or unauthorized use of the medication prescribed.
8) If the medications prescribed may be injected and I chose to inject myself, I agree to hold harmless RevitaLife, RevitaLife personnel and /or RevitaLife physicians if the same results in injury or harm to myself. I understand that RevitaLife and /or its affiliates will provide as much information and Instruction as possible to assist in minimizing harm to myself.
9) I authorize and agree to allow RevitaLife to utilize my lab results, observations and or outcomes of my treatment in future studies which will not disclose my demographic information.
10) I understand that RevitaLife physicians may have elected to opt out of medical malpractice insurance due to the unique and unconventional nature of the medical treatment, and I cannot hold them responsible and will not attempt to hold them responsible for the diagnosis and treatment, risks, potential harm or injuries or outcomes that may result from initiation or continuation of therapy indefinitely.
11) I understand that RevitaLife professionals involved in my care will rely on my documented medical history, as well as other information provided by me, my immediate family, or others having information about me, in determining whether to perform or recommend certain procedures or treatment. Throughout the course of my treatment I agree to provide accurate, updated and thorough information regarding my medical history and any conditions or events, which may impact medical decision making.

**By signing this document, I certify that I have read and understand its contents and the information provided by me is accurate and complete.**

**Patient's Signature** _____ **Patient's Printed Name** _____

**Date** _____

Optional: I hereby authorize RevitaLife to use any of my comments as testimonials for future marketing and advertising.
Initials _____

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## Consent To Use Artificial Intelligence During Encounters

We are committed to providing the best possible care for you, and as part of this commitment, we are continually looking for ways to enhance our services.

We would like to inform you about a new technology that we are using called Freed. Freed is an artificial intelligence (AI) tool that assists us during patient encounters by generating clinical notes based on our conversations. This tool allows us to focus more on you, the patient, and less on computer documentation. The AI tool does not interact with you directly. It merely listens to the conversation and creates a summary.

Freed is a tool that listens to the conversation during the consultation and generates a written summary or "note" based on that conversation. This note is then reviewed and approved by your practitioner.

We want to assure you that your privacy is our utmost priority. The AI tool adheres strictly to Health Insurance Portability and Accountability Act (HIPPA) compliance guidelines to endure your data is secured and protected. Only the healthcare professionals involved in your care will have access to these notes.

Your participation is completely voluntary. If you agree to use the AI scribe during your consultation please sign and date the form below. If you have any questions, please feel free to discuss them with us.

I, _____ consent to the use of Freed during my medical encounters/appointments.

**Patient's Signature** **Date**

**Parent/Guardian Signature (if under 18)** **Date**