COREMEDICALGROUP
CENTER OF REJUVENATION EXPERTS

Patient Registration Form

Date: _____

Patient: _____ Date of Birth: _____

Address: _____ SS#: _____-_____-_____

_____ email: _____

Home Phone: _____ Cell / Office: _____

In Case of Emergency Please Provide Contact Information Below

Name: _____ Relationship: _____

Address: _____

_____

Home Phone: _____ Cell / Office: _____

Email: _____

For Doctor Use Only

COREMEDICALGROUP
CENTER OF REJUVENATION EXPERTS

Therapy Management Agreement

This agreement between ("patient ") and CORE Medical Group establishes guidelines and conditions required for the use of hormone replacement therapy ("HRT") involving DEA "controlled" or "scheduled" medications. CORE Medical Group and patient agree that these guidelines and conditions are an essential factor in maintaining a successful patient / practitioner relationship. Adverse side effects and / or physical / psychological dependence may develop after use of these medications and therefore, these agents are prescribed with caution

The patient agrees and accepts to the following conditions:

1. I understand that the medications I am receiving or will receive are prescribed for me based on diagnoses derived from my submitted medical history, and the results of lab work and a physical examination. The medications are to be used exclusively for treatment of hormonal deficiencies and related medical conditions in accordance with applicable state and federal laws.

2. I understand and agree that no medical treatment or medication provided to me by CORE Medical Group will be used for the purpose of bodybuilding, performance enhancement or physical appearance.

3. I certify that the answers I provide to the health questions on the Health History form and otherwise to CORE Medical Group's affiliated physicians' or laboratories are accurate and correct to the best of my knowledge and that I have not been coached by any third party nor have I knowingly been deceptive for secondary gain, for medical treatment or prescription of a medication.

4. I will not attempt to obtain HRT medications from any other health care practitioner without disclosing my current medical usage of HRT or other medications. I understand that it may be against the law to do so.

5. I have discussed and understand the risks and benefits associated with HRT. I will immediately report and adverse side effects related to the use of my HRT to CORE Medical Group and discontinue use until advised to resume usage by CORE Medical Group. I voluntarily assume any and all possible risks which may be associated with HRT.

6. I understand that representatives of CORE Medical Group and / or Licensed Physicians Assistants are available for questions and / or concerning during normal business hours throughout the course of my treatment.

7. I agree that HRT medications furnished by CORE Medical Group are for my personal use only and for no other purpose. I will not share, sell or trade medications. I will safeguard my medications from loss or theft and will be responsible for their safekeeping.

Patient Initial _____

Therapy Management Agreement Cont,

8. I will be able to purchase the medications from the pharmacy designated by CORE Medical Group and the pharmacy will send medications directly to me. I understand I have the right to purchase my medications from any pharmacy of my choice. If I choose to obtain medications from a pharmacy of my own choice, I must notify CORE Medical Group in writing of my intention to do so and include the name of the pharmacy in my request.

9. I agree and understand that federal regulations prohibit the return of prescribed medications.

10. I understand that HRT treatment and medications are not covered by health insurance. I agree that all services and medications provided by CORE Medical Group or its associated providers are to be paid for in advance. I will not seek reimbursement through my health insurance company, Medicare, Medicaid or other third party payer.

11. I agree that the CORE Medical Group patient / physician relationship is not intended to replace the existing patient / physician relationship with my current primary care provider (PCP) and the treatment provided by CORE Medical Group will be in conjunction with the care provided by my current PCP.

12. I agree that CORE Medical Group only treats patients over the age of 30 with documented symptoms of hormone deficiencies (Hypogonadism and Adult Growth Hormone Deficiency). No prescription will be provided unless a clinical need exists based on required lab work, physician consolation and current health history through either patient's personal physician or a CORE Medical Group affiliated physician. Agreement to lab work does not automatically qualify patient to clinically necessity and prescription of HRT.

I Have Read and Agree to the Terms of the Therapy Management Agreement.

Patient Signature: _____

Printed Name: _____

Date: _____

CORE MEDICAL GROUP
CENTER OF REJUVENATION EXPERTS

MEDICATION MANAGEMENT AGREEMENT

This agreement between _____ (patient) and CORE Medical Group, LLC. Establishes guidelines and conditions required for use of hormone replacement therapy (HRT) involving DEA "controlled" or "scheduled" medications. CORE Medical Group LLC., and (patient) agree that these guidelines and conditions are an essential factor in maintaining a successful patient / physician relationship. Adverse side effects and / or physical / psychological dependencies may develop after repeated use of these medications and therefore, these agents are prescribed with caution.

The patient accepts and agrees to the following conditions:

1. I understand that the medical treatment offered by CORE Medical Group and their physician(s) is not accompanied by any claims, guaranteed, promises or warranties.
2. I understand that the medications I have purchased are prescribed for me based on diagnoses derived from my submitted medical history, blood / lab work, and physical examination. They are to be used exclusively for treatment of these diagnoses.
3. I will not attempt to obtain "scheduled" hormone replacement therapy medications illegally or from any other healthcare practitioner without disclosing my current medication usage. I understand that it's against the law to do so.
4. I will immediately report adverse side effects to the use of my medications to CORE Medical Group and discontinue use until advised to resume usage by CORE Medical Group.
5. I understand that the CORE Medical Group Physician (MD) and / or Licensed Nurse Practitioner are available for questions and / or concerns during normal business hours throughout the course of my treatment.
6. I will safeguard my medications from loss or theft and will be responsible for their safekeeping.
7. I agree that these medications are for my personal use only and no other purpose and I will not share, sell or trade my medications.
8. I agree that I will use my medications at the prescribed rate and dosage and will keep the medications in its respective labeled container.
9. I agree and understand that federal regulations prohibit the return of prescribed medications.
10. I agree to contact CORE Medical Group 4-6 weeks into the start of my therapy (and every 6 months thereafter) to arrange for any follow-up blood testing and / or an office visit / consultation as required by the Core Medical Group Physician.
11. I agree and understand that my fees include a one hundred dollar appointment deposit which will be applied to the cost of my examination, blood work or therapy. To cancel an appointment, I must email my cancellation request to my patient care coordinator at least 48 hours prior to my scheduled appointment time or the $100 deposit will not be refunded.
12. I agree that the CORE Medical Group patient / physician relationship is not intended to replace the existing patient / physician relationship with my current primary care provider (PCP) and my CORE Medical Group treatment will be in conjunction with the care provided by my current PCP.

Patient Signature _____

Patient Printed name _____ Date _____

COREMEDICALGROUP
CENTER OF REJUVENATION EXPERTS

HEALTH INFORMATION AUTHORIZATION

Patient name (Print): _____

Address: _____

Date of Birth: _____ Date of Request: _____

As required by the HIPAA Privacy Regulations, CORE Medical Group, LLC. May not use or disclose your protected health information without your authorization.

1. I hereby authorize CORE Medical Group or any of its employees to use or disclose my Patient Health Information to the following person(s), entity(ies), or business associated with this office (List laboratories, physicians that will receive information)

2. Patient Health information authorized to be disclosed:
   Lab Work, medical history, physician examinations, diagnoses on therapies, telemedicine encounters and tele-health encounters7

3. For the specific purpose of:
   Bio-identical hormone therapy, Andropause Treatment, Menopause Treatment and Hormone Deficiency Treatment7
4.
5. I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

6. Unless otherwise revoked, this Authorization will expire on: _____/_____/_____
   MM DD Year
7. I understand that I have the right to:
   a) Revoke this authorization by sending written notice to CORE Medical Group, LLC. and that revocation will not apply to information that has already been released in response to this authorization.
   b) Inspect a copy of Patient Health information being used or disclosed under federal law.
   c) Refuse to sign this authorization.
   d) Receive a copy of this authorization.
   e) Restrict what is disclosed with this authorization.

8. I understand that my refusal to sign this document will not affect my treatment, payment, enrollment in a health plan, or eligibility for benefits merely because I do not provide authorization to use or disclose protected patient health information.

9. By signing below, I understand and acknowledge that:
   a) I have read and understand this Authorization
   b) If I have any questions about disclosure of my protected information, I may contact my patient manager at CORE Medical Group - 866-641-CORE (2673)

Patient Signature: _____

Date: _____

COREMEDICALGROUP
CENTER OF REJUVENATION EXPERTS

HEALTH HISTORY QUESTIONNAIRE

Name: (Last, First, Mi) _____ M___ F___ **D.O.B:** _____

Marital Status: Single | Partnered Married Separated Divorced Widowed

Previous or referring Doctor: _____ **Date of Last Physical Exam:** _____

PERSONAL HEALTH HISTORY

Childhood Illness: Measles Mumps Rubella Chickenpox Rheumatic Fever Polio		
Immunizations and Dates:	Tetanus _____ Hepatitis _____ Influenza _____	Pneumonia _____ Chickenpox _____ MMR _____ (measles, mumps, rubella)
List any Medical Problems That Other Doctors Have Diagnosed:		
Surgeries: Year Reason Hospital		
Other Hospitalizations: Year Reason Hospital		
Have You Ever had a Blood Transfusion? ☐ Yes ☐ No		

List Your Prescribed Drugs and Over the Counter Drugs, Such as Vitamins and Inhalers:

Name of Drug	Strength	Frequency

Allergies to Medications:	
Name of Drug:	Reaction You Had:

HEALTH HABITS AND PERSONAL SAFTETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONN NAIRE ARE OPTIONAL AND WILL BE KEPT CONFIDENTIAL

Exercise	☐ Sedentary (No Exercise) ☐ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf, etc.) ☐ Occasional Vigorous Exercise (i.e., work or recreation, less than 4 time a week for 30 minutes) ☐ Regular Vigorous Exercise (i.e., work or recreation 4 times a week for 30 minutes)		
Diet	Are You Dieting	☐ Yes	☐ No
	If Yes, Are You on a Physician Prescribed Medical Diet?	☐ Yes	☐ No
	# of Meals You Eat in an Average Day. _____		
	Rank Salt Intake ☐ Hi ☐Med. ☐ Low		
	Rank Fat Intake ☐ Hi ☐ Med. ☐ Low		
Caffeine	☐ None ☐ Coffee ☐ Tea ☐ Cola		
	Number of Cups / Cans Per Day _____		
Alcohol	Do You Drink Alcohol?	☐ Yes	☐ No
	If Yes, What Kind?_____		
	How Many Drinks Per Week? _____		
	Are You Concerned About the Amount You Drink?	☐ Yes	☐ No
	Have You Considered Stopping?	☐ Yes	☐ No
	Have You Ever Experienced Blackouts?	☐ Yes	☐ No
	Are You Prone to "Binge" Drinking?	☐ Yes	☐ No
	Do You Drive After Drinking?	☐ Yes	☐ No
Tobacco	Do You Use Tobacco?	☐ Yes	☐ No
	☐ Cigarettes /packs / day ___ ☐ Chew -# / day ___		
	☐ Pipe / day ___ ☐ Cigars / day ___		
	___ # of Years ____ Year Quit		
Drugs	Do You Currently Use Recreational or Street Drugs?	☐ Yes	☐ No
	Have You Ever Given Yourself Street Drugs with a Needle?	☐ Yes	☐ No
Sex	Are You Sexually Active?	☐ Yes	☐ No
	If Yes, Are You Trying to get Pregnancy?	☐ Yes	☐ No
	If NOT Trying for Pregnancy List Contraceptives or Barrier Method Used: _____		
	Any Discomfort with Intercourse?	☐ Yes	☐ No
	Illness related to the Human Immune deficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include: intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about risk of this illness	☐ Yes	☐ No
Personal Safety	Do You Live Alone?	☐ Yes	☐ No
	Do You Have Frequent Falls?	☐ Yes	☐ No
	Do You Have Vision or Hearing Loss?	☐ Yes	☐ No
	Would You Like Information on Any of These?	☐ Yes	☐ No
	Physical and mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to Discuss This Issue with Your Provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	Age	Significant Health Problems		Age	Significant Health Problem
Father			Children		
Mother			__M __F		
Siblings			__M __F		
__M __F			__M __F		
__M __F			__M __F		
__M __F			Grandmother (paternal)		
__M __F			Grandfather (paternal)		
__M __F			Grandmother (maternal)		
__M __F			Grandfather (maternal)		

MENTAL HEALTH

Is Stress a Major Problem for You?	☐ Yes	☐ No
Do You Feel Depressed?	☐ Yes	☐ No
Do You Panic When Stressed ?	☐ Yes	☐ No
Do You Have Problems With Eating or Your Appetite	☐ Yes	☐ No
Do You Cry Frequently? Have You Ever Attempted Suicide?	☐ Yes	☐ No
Have You Ever Seriously Thought About Hurting Yourself?	☐ Yes	☐ No
Do You Have Trouble Sleeping?	☐ Yes	☐ No
Have You Ever Been to a Counselor?	☐ Yes	☐ No

MEN ONLY

Do You Usually Get Up to Urinate Through the Night?	☐ Yes	☐ No
If Yes, How Many Times? ____		
Do You feel Pain or Burning When Urinating?	☐ Yes	☐ No
Any Blood in Your Urine?	☐ Yes	☐ No
Do You Feel Burning Discharge From Penis?	☐ Yes	☐ No
Has the Force of your Urination Deceased?	☐ Yes	☐ No
Have You Had Any Kidney, Bladder or Prostate Infections within the last 12 Months?	☐ Yes	☐ No
Do You Have Any Problems Emptying Your Bladder Completely?	☐ Yes	☐ No
Any Difficulty with Erection or Ejaculation?	☐ Yes	☐ No
Any Testicle Pain or Swelling?	☐ Yes	☐ No
Date of Last Prostate Exam _____ Rectal Exam _____		

HEALTH HABITS AND PERSONAL SAFTETY Cont.

WOMEN ONLY

Age at Onset of Menstruation _____		
Date of Last Menstruation _____		
Period Every _____ Days		
Heavy Periods, Irregularity, Spotting, pain or Discharge	☐ Yes	☐ No
Number of Pregnancies _____ Number of Live Births _____		
Are You Pregnant or Nursing?	☐ Yes	☐ No
Have You Had a D&C, Hysterectomy or Cesarean?	☐ Yes	☐ No
Any Urinary tract, Bladder or Kidney Infections Within the Last Year	☐ Yes	☐ No
Any Blood in Your Urine?	☐ Yes	☐ No
Any Problem With Control of Urination?	☐ Yes	☐ No
Any Hot Flashes or Sweating at Night?	☐ Yes	☐ No
Do You Have Menstrual Tension, Pain, Bloating, Irritability or Other Symptoms	☐ Yes	☐ No
Around the Time of Period?	☐ Yes	☐ No
Experienced Any Recent Breast Tenderness, Lumps or Nipple Discharge?	☐ Yes	☐ No
Date of Last Pap Exam _____ Rectal Exam _____		

OTHER PROBLEMS

Check If You have Had Any Symptoms in the Following Areas to a Significant Degree and Briefly Explain

☐ Skin_____	☐ Bladder _____
☐ Head / Neck _____	☐ Circulation _____
☐ Ears _____	☐ Recent Changes In: _____
☐ Nose _____	☐ Weight _____
☐ Throat _____	☐ Energy Level _____
☐ Lungs _____	☐ Ability to Sleep _____
☐ Chest / Heart _____	☐ Other Pain /Discomfort_____
☐ Back _____	_____
☐ Intestinal _____	_____

Today's Date: _____

Pre-Placement Physical Examination

Patient: _____ Date of Birth: _____

Address: _____ SS#: _____-_____-_____

_____

Height: _____ Weight: _____ Resting Heart Rate: _____

Blood Pressure: _____ Normal? _____ Elevated Highest Reading: _____

Physical Readings:

General Appearance:	— Normal	— Abnormal
HEENT:	— Normal	— Abnormal
Lymph Nodes:	— Normal	— Abnormal
Chest:	— Normal	— Abnormal
Breats:	— Normal	— Abnormal
Lungs:	— Normal	— Abnormal
Heart:	— Normal	— Abnormal
Abdoman:	— Normal	— Abnormal
Genitalia:	— Normal	— Abnormal
Testes:	— Normal	— Abnormal
Spine:	— Normal	— Abnormal
Neurological:	— Normal	— Abnormal
Skin:	— Normal	— Abnormal

If Abnormal, Please verify findings here:

For Doctor Use Only

Exam Results __ Normal __ Abnormal

Examiner's Printed Name: _____

Examiner's Title: _____

Examiner's Signature: _____

Examiner's Address: _____

Examiner's Phone: _____

CORE MEDICAL GROUP
CENTER OF REJUVENATION EXPERTS

WAIVER

Thank you for your interest in CORE Medical Group, LLC. A company that provides Hormone Replacement Therapy ("HRT"). Individuals seek our medical treatments to replace hormones to improve overall health and well-being.

Before we can provide HRT, Core Medical Group requires the following:

A. Acceptable results of laboratory tests.

B. Verification of access to primary care physician with whom you have had recent (within the preceding 12 months) physical examination (copy of the physical examination is required).

C. An office visit to CORE Medical Group affiliated physician and / or telemedicine counter with a CORE Medical Group affiliated physician.

D. Completion of all CORE Medical Group, LLC. paperwork.

Often individuals who are referred to us have previously received or are currently using medication from other physicians or HRT companies who may or may not follow the same medical evaluation or treatment protocols as we do. In some cases, where inappropriate medications, dosage levels or protocols were provided, an individual's Medical Directors, affiliated physicians and physician extenders take no responsibility and assume no liability for an individual's participation in any prior HRT program. CORE Medical Group, LLC. Does not use or condone the use of performance enhancement protocols or cyclical hormone therapies.

By signing this waiver you are holding CORE Medical Group, LLC. (its employees, physicians, agents and associates) harmless for any damages and liability including without limitation, attorneys fees and costs at all levels of trial and appeal related to health issues that are present or may arise in the future from previous (whether disclosed or undisclosed to CORE Institute) HRT therapies, medication or protocols.

☐ **I certify that I have not previously received HRT and that I am not currently undergoing and / or receiving HRT.**

I have read and agree to the statements, waivers and disclosures in this document.

Patient Signature: _____

Printed Name: _____

Date: _____