Elite Professional Providers, LLC –
The Model that we have in place expedites the process.

First Name_____ Last Name_____

Address_____

City_____State_____ ZIP_____ Date of Birth_____ Race_____ Sex_____

Driver License # (<u>We will need a copy sent</u>) _____

Preferred Contact : Number _____Email_____

Pharmacy Name_____ Phone Number_____

Address_____

City_____ State_____ Zip code_____

PCP or Specialist (If yes), List information

_____

_____

_____

Uninsured _____ (check here)- This is ok we contracted with pharmacies and labs, to make this affordable as possible.

Insurance (Please send cards if available) Insurance Type _____Member ID/Policy Number_____

Allergies (Please list all)

_____

_____

Service that you are looking for: ☐ **Both** ☐ **Men** ☐ **Women**

Weight loss_____ ***Hormone Replacement_____***

Sexual Dysfunction (or) Hypoactive sexual desire _____

Hair loss (Alopecia) _____ ***Excessive Sweating (Hyperhidrosis)_____***

Anti-Wrinkle, Acne treatment (Tretinoin Cream)_____

Insomnia (Ramelteon)_____Shift work sleep disorder(Modafinil, armodafinil) _____

PREP for MEN_____ ***Post sex prophylactic (Doxycycline)_____***

<u>Weight loss</u> Looking for Oral, sublingual or injections.

<u>Oral Medication</u> (Phentermine, Phendimetrazine, Benzphetamine, diethylpropion, Phentermine/topiramate, Contrave, low dose naloxone, Wellbutrin, Orlistat, Metformin)

<u>Sublingual –</u> Semeaglutide SL and <u>Injections –</u> Semaglutide (Wegovy, Ozempic), Liraglutide (Saxenda), Tirzepatide (Zebound, Mounjaro)

Any Medication that you are interested, this give the provider insight of what you are wanting to try, it's not a guarantee but if you meet the criteria, it will make your telemedicine visit more efficient.

Is there anything that you have tried already and failed

_____

_____

<u>Weight loss Question Continue</u>

Remember weight loss isn't always about how much weight you lose, it has multiple factors, (Waist size reduction, loss of fat in focused areas, increase energy, improved self-body image.

Height_____ Weight _____Nurse (Calculate) BMI_____

This Program/ Medication what is most important to you _____

Weight Goal _____ Currently on any Diet (or Diet fads)_____

Activity Level (need this for compliance) Be honest we understand that people are either going to diet and exercise or just want medication management, we don't judge we are here to pick the best plan for you.

_☐_ Inactive - no regular physical with a sit-down job.
_☐_ Some activity- Involved in activities some of the time, such as swimming, golf etc.
_☐_ Heavy/ Vigorous Activity Lifting, Gym, and or Physical exercise at least 3-4 x a week.

Intake of Hydration (fluids, water) How many Cups per days_____

Caffeine (of any kind) How many cups per day_____

Question
Would you like a referral to a health coach, registered dietician, discounted gym memberships, personal trainers or would like to speak to a psychologist (☐ Yes ☐ No) – Nurse will talk with you more?

Do you have recent labs (☐ 4-months ☐ less.) You can use your insurance at a location of your choosing, or we have contracted with lab without insurance all labs for 50 dollars. The choice is yours.

<u>Men's and Women Hormone replacement</u>

Oral Medical, Topical medical, Transdermal, Injections, compound formulas

<u>Men</u>- Testosterone (Oral, Topical, Injection) Compound combinations and offer Clomiphene or alternatives.
<u>Female</u>, Oral, Topical, Transdermal, Vaginal, Compound combination

Is there something that you want to try, or have tried in the past that works for you? Is there something you have tried in the past and it has failed?

_____

Are you taking anything over the counter for hormone replacement, or natural supplements? **(☐ Yes or ☐ No)**

Weight loss and Men's and Women's hormones cross over, with combinations in both categories are needed to achieve one's goal. If taking over the counter hormone supplement- nurse will ask additional questions.

Are you looking to bodybuild or gain muscle with this? Are you having any symptoms to quickly go over (low energy, decrease libido, weight gain, body fat distribution in places not wanted, increase belly fat Vaginal dryness, mood

_____

_____

There were too many options to list in this section, so a provider will go over the individualized options for your treatment plan.
Sexual Dysfunction:
Erectile Dysfunction: (Men) : Oral (Men) Sildenafil (Viagra), Vardenafil, Tadalafil (Cialis), Avanafil Injections (Bi-mix, Tri-mix, Quad-Mix) Option for both ED and Hormone replacement treatment.

Pre-mature Ejaculation Offer: Topical cream, oral medication, Compound medications

What type of Sexual Dysfunction are you having?

_____

Female Hypoactive sexual desire :

Oral Hormone therapy with a combination of compound medication
Fibanserin, bremelanotide, Osphena, addyi, prasterone,
Topical Compound Called scream cream (it increases the blood flow to the area), it helps increase, intensify orgasm, or sensitive in the area.
What type of hypo sexual dire are you having? _____

Hair loss (Alopecia)

- ***A misconception is that there is only one place that people want hair to grow back, you let us know where that is. We Prescribe oral medication (Finasteride), Prescription strength (Bi and tri) compound topical solutions or both.***

Where would you like your hair to grow back at ? _____

Disclaimer if there is anyway that you may be pregnant or wanting to become pregnant, please let us know this would not be a treatment for you at this time.

Excessive Sweating (Hyperhidrosis)

- ***Everyone sweats places all over the body and sometimes it's too much. We offer topical solution, oral medication for this depending on where you excessive sweating is. Also compound solutions.***

Where are the places that you are sweating at that you would like us to take care of?

_____

Anti-Wrinkle, Acne treatment (Tretinoin Cream) we have different strengths and can compound this.
1.) Is this cream used for acne **(☐ Yes ☐ No)**
2.) Is this cream used for an-wrinkles **(☐ Yes ☐ No)**

Insomnia

- ***We only prescribe one medication on this, non-addictive and non-habit forming but give you a great sleep, prescription. Ramelteon. This medication has shown to be effective without interfering with any medication that we would prescribe for any service we offer. How often are you not sleeping at night? Is it falling asleep or staying asleep?***

_____

Shift work disorder ***(working the night shift and just can't stay awake) We prescribe (Modafinil, armodafinil). It can be hard to adjust, and we understand. Are you having trouble staying awake on your shift and having a hard time adjusting? Let's discuss the options.***

_____

PREP for MEN ***Prophylaxis for high-risk men (preventative for HIV)***

1.) ***We will need to have labs to make sure you are negative and then have a few options that you choose from, we only do the oral medication, since we are doing telemedicine and not doing the long-acting injection. Privacy is important to us.***

Post sex prophylactic- ***(symptoms get tested) STI / STD (Doxycycline)***

1.) ***The latest research shows most of the STD if doxycycline is taken after risky sex, it decrease your changes of getting the infection. (We do 1 tab twice a day for 3 days). Talk with your provider about option, and if you have any symptoms gest tested.***

Please fill out this section to the best of your ability. The nurse will double check with you.

Medication Including Supplements

_____

_____

_____

_____

Surgical History (Major surg) _____

Medical Information **Important !!!!!**

Any Type of Cancer (☐ Y ☐ N) -If yes, **the nurse will ask additional question.**
Depression, Anxiety, ADHD, Insomnia, PTSD, Bi-Polar, Schizophrenia, OCD, eating disorder (Please circle One) if not listed

_____

If Yes Below- (Add check mark if applicable)The nurse will ask additional questions.

☐ Hypertension ☐ Stoke (TIA, CVA) ☐ Atrial fibrillation ☐ Cardiac Murmur ☐ Heart Valve Disorder ☐ Stents ☐ Heart Surgery
☐ Factor V ☐ (Hx or current- Pulmonary embolism, DVT) ☐ Congestive Heart Failure
☐ COPD / Asthma ☐ Anemia ☐ Thyroid disorder ☐ Pancreatitis (acute or Chronic)
☐ Liver disease ☐ Hepatitis ☐ Kidney Disease ☐ Diabetes Type 1 ☐ Diabetes Type 2
☐ High Cholesterol or High triglycerides ; ☐ Epilepsy /Seizure Disorder ☐ Migraines / Headaches ☐ IBS ☐ Constipation
☐ Chronic diarrhea

Do You ; Smoke _____ Packs ; Alcohol _____Drinks per week; Cannabis/ CBD _____

Elite Professional Providers, LLC
Informed Consent to Telemedicine Consultations

Men's and Women's health is a **telemedicine service only**. Telehealth involves the delivery of healthcare services using electronic communications, information technology or other means between a healthcare provider and a patient who are not in the same physical location. Telehealth may be used for diagnosis, treatment, follow-up and/or patient education, and may include, but is not limited to, one or more of the following: electronic transmission of medical records, photo images, personal health information or other data between a patient and a healthcare provider; interactions between a patient and healthcare provider via audio, video and/or data communications (such as secure messaging); use of output data from medical devices, sound and video files.

I understand that any medical treatment may involve risks as well as the proposed benefits. I have been explained different benefits and risks involved with my overall treatment plan and the different types of medication that my provider might prescribe to me. I also understand that medical recommendations are subject to change based upon the change of guidelines or evidence-based practice.

I understand and agree to the following.

1. The laws that protect the privacy and confidentiality of medical information also apply to telemedicine.
2. I have the right to withhold or withdraw my consent to the use of telemedicine during my care at any time. I understand that my withdrawal of consent, since we are a fully telemedicine company, would terminate care with us.
3. Telemedicine May involve electronic communication of my personal medical information to other practitioners who may be in other areas, including out of state.
4. I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured. My condition may not always be cured, or improved and in some cases may get worse.

I am executing this informed consent document (Informed consent) to verify and confirm my discussion with the provider regarding the risk, benefits, and alternative to treatment through weight loss medication we offer. I also give my informed consent regarding telemedicine for the use of my medical care.

Signature of Patient _____ Date_____
Typing your name as a signature

Witness_____ Date _____

Elite Professional Providers, LLC Notice of Privacy Practices for Protected Health Information

- *Your Information. Your Rights. Our Responsibilities.*
- This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information.

Your Rights

- When it comes to your health information, you have certain rights. This section explains your rights and responsibilities.

1. Get a List of Those with Whom We Have Shared Information:

- You can obtain a list of disclosures of your health information for the 7 years prior to the date you ask. This list will include who we shared your information with and the reasons for such sharing.

2. Limiting Shared Information:

- You may request a restriction on certain uses and disclosures of your health information. If you pay for a service or healthcare item out of pocket and in full, you can ask us not to share this information for the purpose of payment or our operations with your health insurer. We will abide by the request unless we become legally required to share this information.

3. Request Confidential Communications:

- You can ask us in writing to contact you in a specific way. If you do not provide specific instructions, we will use the information you provided in the intake form.

4. Correcting Your Medical Record:

- You may request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office. While we will make every effort to fulfill this request, please note that we cannot change information that was not created by us unless the person who created it is no longer available or is not part of the health information kept by or for the office. If your request is denied, we will provide you with the reason for denial.

5. Medical Record Copy:

- You can request to inspect and obtain a copy of your health and billing records. A written request must be delivered to the office. We will provide you with a copy or summary of your health information, usually within 14 business days of your request. A reasonable, cost-based fee will be charged in accordance with state regulations.

For any questions or concerns regarding your privacy rights, please contact our office and talk with Tina @ 417-220-4480

We value your trust and are committed to protecting the privacy and security of your health information.

Elite Professional Providers, LLC
3322 S CAMPBELL AVE STE T-1
SPRINGFIELD MO 65807-4980
Office Phone: 417-220-4480
Office Fax: 417-414-0017

Refund and Appointment Rescheduling Policy

Elite Professional Providers, LLC - Men's and Women's Health

- At Elite Professional Providers, LLC, we prioritize the well-being and convenience of our patients. Please familiarize yourself with our refund and appointment rescheduling policy outlined below:

Rescheduling or Canceling Your Tele-visit:

- Patients have the flexibility to cancel or reschedule their appointments without incurring additional charges if the request is made at least 48 hours prior to the scheduled appointment through our patient portal, or by calling.

Fee and Credit:

- (depending on service) fee will be applied to cancellations or rescheduling occurring within 48 hours of the appointment.
- The fee will be credited towards the patient's next appointment, allowing them to conveniently utilize the payment they have already made.

No-Show Policy:

- Patients who do not provide notice or "no-show" for their tele visit will not be eligible for a refund.

Importance of No-Show Policy:

- Our no-show policy is essential to maintaining our elite professional providers and ensuring the availability of resources for all patients.

Exceptions:

- In cases of unforeseen circumstances, patients must fill out a refund submission form to be considered for any refund. This will be done on a case-by-case basis.
- Please be aware that decisions regarding refunds may take up to 5-7 business days.

We appreciate your cooperation and understanding of these policies. It is the patient's responsibility to abide by and understand these policies, if they do not, please don't hesitate to ask our support team.

Thank you for choosing Elite Professional Providers for your health and wellness needs.

Note: The mentioned dollar amounts are illustrative and may vary based on the specific services provided.

This refund policy is sent with every intake form. This form does not need to be signed, but automatically is in effect as you become a patient of Elite Professional Providers, LLC.

Next steps

Nurse will be reaching out to you shortly (by your preferred contact).

Financial Responsibility:

Elite Professional Providers, LLC (Men's and Women's) health is a Cash only service (we accept Major Credit Cards, Debit cards) and other forms of payment. Your insurance (You may use for labs and medication) if your insurance doesn't pay you are fully financial responsible No insurance may be used on compounding medication.

We do collect payment in full prior to your scheduled visit.

I understand and agree with the following.

I have received the refund policy, the privacy statement, the informed consent which I have signed. I also agree with the financial statement knowing that I am financially responsible for services (in full) and what my insurance doesn't pay.

I give Elite Professional Providers, LLC permission and authorization to access the prescription database before prescribing medication, to obtain a copy of my current medication, release of my medical record from other providers involved in my care and authorize my payment (by the acceptable methods) by elite professional providers in the full amount of what is due by signing below.

Singing below means that I fully understand to everything stated above and this signature makes me responsible for this whole document and agree with everything.

Full Name (Print) _____

Sign _____ ***Date*** _____

(Typing your name as a signature)

Please Email this form back to Info@EPP.LLC and or Fax back @ 417-414-0017

We will get back with your shortly and thank you for taking the time to fill this out, we appreciate you.