

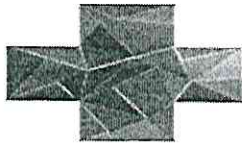


**Medical History Information:**

Patient Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_  
 Known Drug Allergies: \_\_\_\_\_  
 Sex: M / F      Age: \_\_\_\_\_      Height: \_\_\_\_\_      Weight: \_\_\_\_\_  
 Date of last physical: \_\_\_\_\_      Date of last Menstrual Period: \_\_\_\_\_  
 Date of last Pap: \_\_\_\_\_      Date of last Mammogram: \_\_\_\_\_  
 Surgeries: \_\_\_\_\_

**Have you ever had any chronic problems with the following?**

	<u>YES</u>	<u>NO</u>	<u>EXPLANATION</u>
Ears, Nose, Throat			
Eyes			
Headaches			
Respiratory/ Lungs			
Joint (legs/Arms)			
Stomach/GI			
GYN (ovaries, Uterus, Cervix, Menstruation)			
Heart			
Bladder			
Kidneys			
Urination			
Blood Disorder			
Testicle / Penis			
Sexually transmitted disease			
Skin			
Mental Health (anxiety, depression, sleep problems, etc.)			



**It Is Well**  
Healthcare

**MEDICATION LIST**

Allergies to Medications: \_\_\_\_\_

Allergies to food: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ City/Town: \_\_\_\_\_

Medication Name	Dose/ Strength	Times Per Day

**Please list all doctors/specialists that you follow with below:**






# It Is Well Healthcare

## HIPAA

### NOTICE OF PRIVACY PRACTICES

In accordance with the law, It Is Well Healthcare supports and upholds all matters pertaining to the privacy of your protected health care information. We will fully adhere to all legal requirements regarding your protected health care information, but reserve the right to change our privacy practices at any time as permitted by the law. If our privacy practices change, we will post a notice in our reception area, and provide you with a copy of the document changes.

#### CLIENT CONSENT FOR DISCLOSURE AND USE OF PROTECTED HEALTH INFORMATION

I hereby consent to the utilization and disclosure of my protected health information by It Is Well Healthcare. In addition, I give my consent to provide treatment and secure payment, and other health care operations as related to my care. I have read/reviewed the Privacy Practice Statement (as above), prior to signing this consent, I understand that It Is Well Healthcare is required by law to report suspected or diagnosed child abuse and neglect; and conditions identified as "reportable conditions" by statute to the State Public Health Office.

It Is Well Healthcare may mail to my home, or other designated location, may correspond with me via telephone, leave verbal messages on my voicemail, or speak with me in person, in reference to any items or issues that will assist in the provision of my care, payment, and or other health care operations such as, insurance item, follow-up communication, X-ray and / or laboratory results, or other, pertaining to my care. This includes the transfer of my protected health information (if required) by postal mail, as long as the consents are addressed to me personally and are marked "personal and confidential" or are delivered by It Is Well Healthcare.

I further realize that I have the right to request that It Is Well Healthcare, restrict the use / disclosure of my personal health information regarding treatment, payment, and / or other health care operations or activities. However, It Is Well Healthcare is not required to agree to my requested restrictions. If It Is Well Healthcare does not agree to my requested restrictions; they are bound by the legal constraints regarding the privacy and protection of my health care information

I have read and understand the Notice of Privacy Practices and Consent for Use and Disclosure of Protected Health Information

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date:



# It Is Well Healthcare

## Patient Financial Responsibility

I (We) jointly and severally, agree to pay all of the charges for professional services rendered to the patient.

I (We) understand that these charges are in addition to charges by a hospital or other medical professional rendering services to the patient.

I (We) Promise to pay the charges in full at the time a bill is presented, unless other terms have been agreed to in writing. In the event prompt payment is not made, the undersigned understands that the account may be referred for collection. In such an event any unpaid balance shall accrue interest at the rate of 2% of the amount due. **We also use third-party vendors such as LabCorp, Quest, and Bayhealth for labs Imaging and studies. If you are self-pay and or your insurance does not cover these vendors you may receive a bill for their products and services in which you agree and would be financially responsible to pay these vendors directly.**

If the patient has provided insurance information, It Is Well Healthcare, LLC may, but it is not required to assist the patient in the filing of a claim.

I request and authorize that payment of authorized Insurance Company benefits may be made on my behalf to It Is Well Healthcare for any services furnished to or by this company. I authorize any holder of medical information about me to be released to any insurance company(s) any information needed to determine benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare / other insurance company assigned cases, It Is Well Healthcare agrees to accept the charge determination of the Medicare / other insurance company as the full charge, The patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare / other insurance company.

**Patient Signature:** \_\_\_\_\_

**Responsible Party:** \_\_\_\_\_



**It Is Well**  
Healthcare

**Medical Appointment Cancellation/No Show Policy**

Thank you for trusting your medical care to It Is Well Healthcare. When you schedule an appointment with It Is Well Healthcare we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our appointment cancellation/no show policy below:

- Effective November 1, 2022 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours notice** will be considered a no show and charged a **\$25.00 fee**.
- If a **fourth** no show or cancellation/reschedule with no 24 hour notice should occur the patient may be **dismissed** from It Is Well Healthcare.
- Any new patient who fails to show for their initial visit will not be rescheduled after 2 no shows.
- The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit**.
- **Effective JULY 1<sup>st</sup>, 2024, Late Arrival Appointment Policy UPDATE. When we reserve time for you, we require all that time to provide you with the best quality care possible. When you are late it decreases our ability to accomplish this. If you arrive late, your appointment may be rescheduled in order to meet the needs of those who are on time for their pre-reserved visit. If you call ahead to say you will be late, this does not alter the policy. We only allow a 5 (FIVE) minute window of time before you are considered to be a NO SHOW and you will be rescheduled.**
- As a courtesy, we make reminder calls for appointments. If you do not receive a reminder call or message, that above policy will remain in effect.

We understand that there may be times when an unforeseen emergency occurs and you may not be able to keep your appointment. If you should experience extenuating circumstances please contact our office, who may be able to waive the no show fee. You may contact It Is Well Healthcare at the number listed below. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message.

It Is Well Healthcare (302-678-9355)

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

\_\_\_\_\_  
Signature (Parent/Legal Guardian)

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

How did you hear about us? \_\_\_\_\_



**It Is Well**  
Healthcare

**NOTICE**

By Federal Law and Managed Care Contract Law, this office is required to collect co-payment and deductible for each encounter.

PENALTY FOR NOT FOLLOWING THIS REQUIREMENT COULD RESULT IN THE TERMINATION AND CANCELLATION OF MEDICAL COVERAGE FOR THE PATIENT.

Our agreement with health insurance plans require us to collect co-payment and deductibles At the time services are rendered.

The Center for Medicare and Medicaid Services required that we collect co-insurances And deductibles from Medicare beneficiaries.

Please help us comply with these requirements by making your co-payments today. We Accept cash, check and all major credit cards.

Thank you !

**Patient Initials:** \_\_\_\_\_



# It Is Well Healthcare

Amanda D. Boone, APRN  
Hannah Hierlmaier, MSN, FNP  
Jessi Thompson, FNP-C  
29,31 and 33 Gooden Ave  
Dover, DE 19904  
(P) 302-678-9355 (F) 302-678-9310

## **Patient Financial Responsibility Form/ Self-Pay Consent** **\*\* Please complete and sign this form if you are self-pay!**

This is a fee for service / Self pay visit  
It Is Well Healthcare Self-Pay rates are as follows....  
\$100.00 standard provider visit  
\$125.00 New Patient / Establishment appointment  
\$25.00 Nurse Visit

And will not be billed to your insurance (in the case that there is insurance)

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date: \_\_\_\_\_

I attest that:

This Self-Pay Agreement is intended to provide patients and parents/legal guardians with an understanding of their financial responsibilities should they elect to self-pay for It Is Well Healthcare services.

By signing this agreement, I, \_\_\_\_\_  
(patient or parent/legal guardian), understand and agree that:

1. I am not currently enrolled in or eligible for Medicare, Tricare, or Medicaid
2. I represent that (check appropriate box below)
  - o I have health insurance coverage; however, It Is Well Healthcare does not currently accept my health insurance plan.
  - o I do not currently have health insurance coverage.

**It Is Well, LLC Primary Care Rules and Regulations / Consent to Treat:**

Please make sure the patient's insurance card and identification card are present during your appointment, along with any insurance co-pays.

Please notify the office immediately if your insurance changes and please bring us a copy of the new card for billing purposes.

We respectfully request a 24-hour advance notice if you need to re-schedule or cancel your appointment.

Children under the age of 18 must be accompanied by a parent / guardian. If someone other than the parent / guardian is present with the child, then a note from the parent / guardian must be written and present with the patient at the time of the visit giving permission for treatment on that day.

Please allow 24 to 48 hours for all prescription refills to be completed by the office. Please be sure to call in your refill requests to the office at least 3 Days prior to your last dose, this will help to prevent from being out of medication(s). Make sure to call your pharmacy before picking up the medication to make sure the prescription is ready.

If you are referred to a specialist or require any type of diagnostic testing and your insurance requires a referral /authorization, please notify the nurse, and please allow 24-48 hours for the office to complete the referral / authorization

Please initial on the line below if you allow the office to leave a message on your voicemail in regards to any appointment reminders (this includes but not limited to specialists, medication refills and / or radiography studies). Initials: \_\_\_\_\_

**PERMISSION TO TREAT**

I HEREBY AUTHORIZE IT IS WELL HEALTHCARE, LLC TO EVALUATE AND TREAT ME FOR MY PRESENTING CONDITION. I UNDERSTAND THAT THE PROVIDER EVALUATING ME MAY IN HIS/HER PROFESSIONAL OPINION, DETERMINE THAT I NEED TO BE TRANSFERRED TO A HIGHER LEVEL OF CARE SUCH AS THE EMERGENCY DEPARTMENT. I AGREE TO PAY FOR ANY AND ALL MEDICAL SERVICES RENDERED AT IT IS WELL HEALTHCARE LLC.

SIGNATURE: \_\_\_\_\_

PRINTED NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ DATE: \_\_\_\_\_

## MRS Checklist - BEFORE HRT (W)

Place an "X" for EACH symptom you are currently experiencing. Please mark only ONE box.

For symptoms that do not apply, please mark NONE.

	SCORE:	None 1	Mild 2	Moderate 3	Severe 4	Extremely Severe 5
1. <b>Hot flashes, sweating</b> (episodes of sweating)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. <b>Heart discomfort</b> (unusual awareness of heart beat, heart skipping, heart racing, tightness)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. <b>Sleep problems</b> (difficulty in falling asleep, difficulty in sleeping through the night, waking up early)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. <b>Depressive mood</b> (feeling down, sad, on the verge of tears, lack of drive, mood swings)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. <b>Irritability</b> (feeling nervous, inner tension, feeling aggressive)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. <b>Anxiety</b> (inner restlessness, feeling panicky)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. <b>Physical and mental exhaustion</b> (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. <b>Sexual problems</b> (change in sexual desire, in sexual activity and satisfaction)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. <b>Bladder problems</b> (difficulty in urinating, increased need to urinate, bladder incontinence)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. <b>Dryness of vagina</b> (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. <b>Joint and muscular discomfort</b> (pain in the joints, rheumatoid complaints)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please share any additional comments about your symptoms you would like to address.

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Do you have cold hands and feet?  Yes  No      Do you have daily bowel movements?  Yes  No

Do you have gas, bloating or abdominal pain after eating?  Yes  No

Please select your WEEKLY Activity Level based on this criteria → *Physical activity that accelerates heart rate / Breathlessness*

0-1 day per week (Low)       2-3 days per week (Average)       More than 3 days per week (High)

Please list any prior hormone therapy?

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**FOR OFFICE USE ONLY**

CHART ID: \_\_\_\_\_ DOB: \_\_\_\_\_ APPT DATE: \_\_\_\_\_

# AMS Checklist - BEFORE HRT

(M)

Place an "X" for EACH symptom you are currently experiencing. *Please mark only ONE box.*  
For symptoms that do not apply, please mark NONE.

	SCORE:	None 1	Mild 2	Moderate 3	Severe 4	Extremely Severe 5
1. <b>Decline in your feeling of general well-being</b> (general state of health, subjective feeling)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. <b>Joint pain and muscular ache</b> (lower back pain, joint pain, pain in a limb, general back ache)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. <b>Excessive sweating</b> (unexpected/sudden episodes of sweating, hot flushes independent of strain)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. <b>Sleep problems</b> (difficulty in falling asleep difficulty in sleeping through, waking up early and feeling tired, poor sleep, sleeplessness)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. <b>Increased need for sleep, often feeling tired</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. <b>Irritability</b> (feeling aggressive, easily upset about little things, moody)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. <b>Nervousness</b> (inner tension, restlessness, feeling fidgety)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. <b>Anxiety</b> (feeling panicky)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. <b>Physical exhaustion / lacking vitality</b> (general decrease in performance, reduced activity, lacking interest in leisure activities, feeling of getting less done, of achieving less, of having to force oneself to undertake activities)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. <b>Decrease in muscular strength</b> (feeling of weakness)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. <b>Depressive mood</b> (feeling down, sad, on the verge of tears, lack of drive, mood swings, feeling nothing is of any use)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. <b>Feeling that you have passed your peak</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. <b>Feeling burnt out, having hit rock-bottom</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. <b>Decrease in beard growth</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. <b>Decrease in ability/frequency to perform sexually</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. <b>Decrease in the number of morning erections</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. <b>Decrease in sexual desire/libido</b> (lacking pleasure in sex, lacking desire for sexual intercourse)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please share any additional comments about your symptoms you would like to address. \_\_\_\_\_

Do you have cold hands and feet?  Yes  No

Do you have daily bowel movements?  Yes  No

Do you have gas, bloating or abdominal pain after eating?  Yes  No

Please select your WEEKLY Activity Level based on this criteria → *Physical activity that accelerates heart rate / Breathlessness*

0-1 day per week (Low)     2-3 days per week (Average)     More than 3 days per week (High)

Please list any prior hormone therapy? \_\_\_\_\_

Recent PSA: \_\_\_\_\_ Recent Digital Rectal Exam (Date): \_\_\_\_\_ Normal / Abnormal

History of Prostate problems or Biopsy. If so, please provide details. \_\_\_\_\_

### FOR OFFICE USE ONLY

CHART ID: \_\_\_\_\_ DOB: \_\_\_\_\_ APPT DATE: \_\_\_\_\_