INFORMED PATIENT CONSENT

I, _________________________________ specifically authorize Male Medical Group (MMG) to perform an evaluation and develop for me a suggested plan for optimal health. I warrant that all information that I have submitted for my evaluation is true to the best of my knowledge.

Hormone Replacement Therapy

I request and consent to the testing of my hormone levels to establish my baseline hormone levels and agree to the administration of hormone medication if I am medically qualified. I agree to have these medications prescribed by the licensed medical provider at MMG. I acknowledge that there are no guarantees or promises made with respect to how much I will benefit from the hormone supplementation therapy prescribed for me.

I understand that with testosterone replacement therapy, as with any other therapy, there may be side effects. Side effects of testosterone replacement may include any or all the following: mood changes, acne, hair loss, prostate enlargement, breast tissue enlargement or testicular shrinkage. I agree to report to the medical provider any adverse reaction or problem that might be related to my hormone therapy.

I understand that with hormone supplementation there are possible risks and complications if I do not comply with the recommended dosages. I will conform and comply with the recommended dosages and methods of administration. I understand that the role of MMG is for the management of my hormone replacement only and I agree that the medical provider for MMG will not take the place of my personal medical provider in this regard.

Erectile Dysfunction (ED) / Premature Ejaculation (PE) Treatment

Male Medical Group offers a variety of options to aid in the treatment of Erectile Dysfunction and Premature Ejaculation.

A series of diagnostic tests may be performed to aid in developing the proper treatment for erectile dysfunction or premature ejaculation. The first test is called an Echo Doppler Ultrasound and is performed by locating the cavernosal artery in the penis to measure the "passive" blood flow (when you are not sexually excited). The staff member will then apply a painless test dose of medication to the spongy tissue of the penis using an auto-applicator. The medication in the test dose contains a combination of commonly used vasodilators including Papaverine, Phentolamine, Atropine, and Prostaglandin EI that will dilate the blood vessels of the penis so that the "active" blood flow (as when you are sexually excited) can be measured by a second Echo Doppler Ultrasound. A partial or full erection lasting 40-60 minutes usually results from the application of the medication. *

The application of the test dose of medication may produce a full erection lasting longer than two hours which is uncommon and only occurs in those who are overly sensitive to the combination of medication being used. Should such a prolonged erection occur, you will be advised on what procedures should be followed.

*** I understand that Male Medical Group of San Antonio guarantees that in the event I fail to achieve an erection during the initial office visit, there will be no charge for the office visit. However, in the event that**

I complete the office visit having achieved the erection, the cost of the office visit, the medications, and/or other services or products, shall be non-refundable and the no cost GUARANTEE shall terminate at the time the office visit had ended.

Consultation Fee and Insurance

I understand that the initial consultation and diagnostic testing are covered by the consultation fee of $______ and understand that the charges paid for any other medication which I may elect to purchase are final. I also understand that some insurance companies may not pay for hormone supplementation therapy or any services considered elective treatments and I agree to pay for any services including laboratory charges that are not covered by my insurance company, with the understanding that I may not be reimbursed for professional fees. I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive, and I agree to make payment in full. I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered. I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full. I also understand and agree that any medication ordered by me are by law non-refundable.
I hereby authorize Male Medical Group of San Antonio to maintain the medical records and medical charts for medical services provided to me, and I have read and understand the Male Medical Group of San Antonio HIPAA Statement and Notice of Privacy Practices.

Patient’s Signature: Date:

Medical Provider’s Signature:

Male Medical Group of San Antonio

Patient Profile Sheet

(Please Print Clearly)

Name: Date:

Physical Address: Mailing Address:

(If different than physical address)

City: City:

State: Zip: State: Zip:

Contact Number: Alternate Number:

Age: Date of Birth: Work Number:

Employer: Occupation:

Driver's License:

SSN:

Email address:

Insurance Carrier: ID Number: Group Number:

Marital Status: __Single __Married __Divorced __Separated __Widowed

Physical Activity: __Inactive __Light __Moderate __Heavy

Weight:

Height:

How did you hear about Male Medical Group of San Antonio?

☐ Newspaper: Which one?

☐ Internet: Which website?

☐ Television: Which program?

☐ Billboard: Location?

☐ Radio: Which station?

☐ Friend: Whom can we thank?

☐ Other:

ADAM Questionnaire

(**A**ndrogen **D**eficiency in the **A**ging **M**ale)

The ADAM Questionnaire was developed by a physician and is used extensively by healthcare providers to help identify men who may have low testosterone. However, to confirm that you have "Low T", a blood test will be performed to determine if your testosterone levels are within a treatable range.

Please check all that you may be experiencing.

1. ☐ Have you previously been diagnosed with Low Testosterone?
2. ☐ Have you had a decrease in Libido (Sex Drive)?
3. ☐ Have you had a lack of energy?
4. ☐ Do you have a decrease in strength and/or endurance?
5. ☐ Have you noticed a decreased "enjoyment of life"?
6. ☐ Do you experience foggy memory or lack of focus?
7. ☐ Do you experience sleeplessness or night sweats?
8. ☐ Have you experienced weight gain or difficulty losing weight?
9. ☐ Are your erections less strong?
10. ☐ Are you falling asleep after dinner?
11. ☐ Have you lost height?
12. ☐ Are you sad and/or grumpy?
13. ☐ Have you noticed a decrease in your ability to play sports?
14. ☐ Has there been a decrease in your work performance?

Medication Authorization

I, ____________________________, authorize Male Medical Group to accept and store on my behalf, prescription medication in my name shipped to their office at 14615 San Pedro Ave, Suite 100, San Antonio, TX 78232.

____
Signature

Medical Questionnaire

Medical History
(Please circle yes or no)

Have you been cleared by your doctor to have sexual activities? Yes No

Have you ever been diagnosed or treated for any of the following?

Diabetes	Yes	No	High Cholesterol	Yes	No
High Blood Pressure	Yes	No	Bleeding Disorder	Yes	No
Heart Disease	Yes	No	Stroke	Yes	No
Multiple Sclerosis	Yes	No	Parkinson's disease	Yes	No
Epilepsy	Yes	No	Liver Disease	Yes	No
Hepatitis	Yes	No	Kidney Disease	Yes	No
Bowel Problems	Yes	No	Prostate Disease (BPH)	Yes	No
Peyronie's Disease	Yes	No	Prostate Cancer	Yes	No
Sexually Transmitted	Yes	No	HIV Infection / AIDS	Yes	No
Blood Transfusion	Yes	No	Major Depression	Yes	No
Tuberculosis	Yes	No	Leukemia / Myeloma	Yes	No

Other Ailments Not Listed Above

Surgery

Heart	Yes	No	Blocked Artery	Yes	No
Prostate	Yes	No	Penis	Yes	No
Bowel	Yes	No	Bladder	Yes	No
Hernia	Yes	No	Head	Yes	No
Scrotum / Testes	Yes	No	Spine	Yes	No

Other ____

Previous Urology Problems

Kidneys	Yes	No	Penis	Yes	No
Bladder	Yes	No	Testicles	Yes	No
Prostate	Yes	No	Urine	Yes	No

Injuries

Head	Yes	No	Back	Yes	No
Pelvis	Yes	No	Penis	Yes	No

Other

Social History

Do you Drink Alcohol? Yes No If so, how often

Do you Smoke Tobacco?	Yes	No	If so, how often
Do you use Recreational Drugs?	Yes	No	If so, how often

Family History

Is anyone in your immediate family being treated for any of the following?

Diabetes	Yes	No	Premature Heart Attack	Yes	No
Cancer of the Prostate	Yes	No	High Blood Pressure	Yes	No

Other Family Ailments Not Listed Above

Allergies

Are you allergic to or have you ever had an allergic reaction to any medications or foods? Yes No

If yes, please provide details:

Questionnaire (continued)

Medications:
Please list **ALL medication**s including any vitamins or supplements that you are currently taking. If none, please write none. If you have a prepared list, please write SEE LIST and present your list to a staff member.

____

____

____

<u>What is the primary reason for your visit today?</u>

<u>Please check below all other services that you would like information on:</u>

- ☐ Weight Loss
- ☐ Erectile Dysfunction
- ☐ Hair Removal
- ☐ Chin / Neck Tightening
- ☐ Botox / Fillers (Facial Aesthetics)
- ☐ CoolSculpting / Permanent Fat Reduction
- ☐ Acne Treatment
- ☐ Exosomes (Mesenchymal Stem Cells)
- ☐ IV Vitamin Therapy
- ☐ Growth Hormone / Peptides
- ☐ Hormone Replacement Therapy
- ☐ GAINSWave Therapy / Penile Rejuvenation
- ☐ PRP (Platelet Rich Plasma) / Hair Restoration
- ☐ Supplements / Vitamins
- ☐ CoolTone / Magnetic Muscle Stimulation
- ☐ Skin Rejuvenation / Laser Resurfacing
- ☐ Skin Care Products (SkinCeuticals)

<u>Main Sexual Complaints Today if any:</u>			If yes, how long have you had this problem?
Difficulties in getting an erection	Yes	No	
Difficulties in maintaining an erection	Yes	No	
Early Ejaculation	Yes	No	
Unable to ejaculate	Yes	No	
Painful ejaculation	Yes	No	

Please describe your main sexual complaints:

____

Have you used any medications for Erectile Dysfunction or Enhancement?

Please Circle One			Side Effects, if any	Results			Used in the last 48 hrs	
Viagra	Yes	No		Poor	Fair	Good	Yes	No
Cialis	Yes	No		Poor	Fair	Good	Yes	No
Levitra	Yes	No		Poor	Fair	Good	Yes	No
Injections	Yes	No		Poor	Fair	Good	Yes	No
Muse	Yes	No		Poor	Fair	Good	Yes	No

Non-prescription/Other Enhancing Medication

The following to be completed by Physician or staff member

Medical History Review Conducted by: ____ MD/PA/NP